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# The Illinois Medical Journal

**The Official Journal Of**

## The Illinois State Medical Society

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**July — December, 1950**

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# The ILLINOIS Medical Journal

VOL. 98 NO. 1

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## Treatment of Peripheral Vascular Disorders

## Aureomycin in the Treatment of Acute Anterior Poliomyelitis

## House of Delegates

(See page 5 for Table of Contents)

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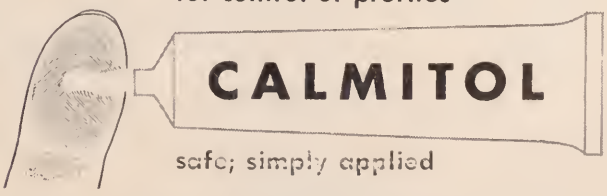


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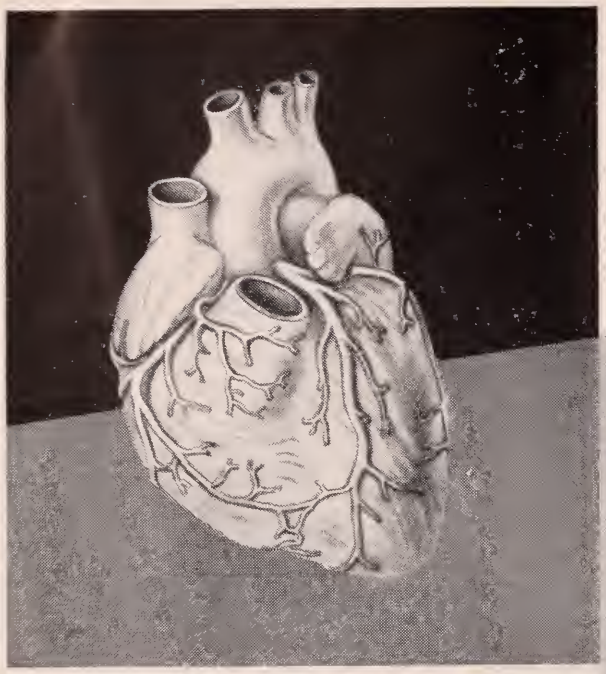
Merrell
1828
CINCINNATI • U.S.A.

**When vasodilation alone is indicated.** *Nitranitol.* (½ gr. mannitol hexanitrate.)

**When sedation is desired.** *Nitranitol with Phenobarbital.* (¼ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

**For extra protection against hazards of capillary fragility.** *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

**When the threat of cardiac failure exists.** *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ¼ gr. Phenobarbital and 1½ grs. Theophylline.)



announcing

# 'ESKEL'

**a superior presentation of khellin**

## a new and promising attack on the problem of **anginal pain**

'Eskel' is an outstanding new coronary vasodilator . . .
with a prolonged therapeutic action.

Exhaustive pharmacological studies have shown that 'Eskel' has a considerably greater coronary dilating activity than aminophyllin in the isolated heart. (Eskel's activity is reported to be at least *5 times the coronary dilating activity of aminophyllin.*)[1] It has no demonstrable effect on the myocardium; a negligible effect only on blood pressure and pulse rate.

Cardiologists have demonstrated that 'Eskel' gives marked relief to a high percentage of angina pectoris patients[2,3] . . . and is of considerable value in chronic bronchial asthma.[4]

'Eskel' is packaged in bottles of 50 tablets. Each tablet contains a mixture of active principles, chiefly khellin, extracted from the plant Ammi visnaga, equivalent to 40 mg. of crystalline khellin.

*Smith, Kline & French Laboratories, Philadelphia*


1. Killam, K.R., and Fellows, E.J.: Federation Proc. 9:291 (March) 1950.
2. Rosenman, R.H., et al.: J.A.M.A. 143:160 (May 13) 1950.
3. Osher, H.L., and Katz, K.H.: Boston M. Quart. 1:11 (March) 1950.
4. Kenawy, M.R., et al.: Eye, Ear, Nose & Throat Monthly 29:79 (Feb.) 1950.


'Eskel' Trademark

# NO's worth noting

Potent therapeutic agents may be two-edged swords—clinical efficacy coupled with varying degrees of toxicity. CHLOROMYCETIN is a powerful sword with a single edge. It exerts a remarkable antibiotic effect on a wide range of infections (including many unaffected by penicillin, streptomycin or the sulfonamides). At the same time, it is unusually well tolerated. Published reports emphasize its relative innocuousness.

"**NO significant untoward effects** in patients who received chloramphenicol under our care."

Smadel, J. E.: J.A.M.A. *142*:315, 1950 (discussion)

"**NO evidence of renal irritation** . . . No impairment of renal function. . . . **No changes in the red-cell or white cell series** of the blood . . . nor did jaundice occur. . . . Drug fever was not observed . . . side effects were slight and infrequent."

Hewitt, W. L., and Williams, B., Jr.: New England J. Med. *242*:119, 1950

"**NO toxic reactions** or signs of intolerance were observed."

Payne, E. H.; Knaudt, J. A., and Palacios, S.: J. Trop. Med. & Hyg. *51*:68, 1948

"**NO symptoms or signs of toxic effects** attributable to the drug were observed."

Ley, H. L., Jr.; Smadel, J. E., and Crocker, T.: Proc. Soc. Exper. Biol. & Med. *68*:9, 1948

# CHLOROMYCETIN®

**CHLORAMPHENICOL, PARKE-DAVIS**

CHLOROMYCETIN is effective orally in urinary tract infections, bacterial and atypical primary pneumonias, acute undulant fever, typhoid fever, other enteric fevers due to salmonellae, dysentery (shigella), Rocky Mountain spotted fever, typhus fever, scrub typhus, granuloma inguinale, and lymphogranuloma venereum.

**PACKAGING:** CHLOROMYCETIN is supplied in Kapseals® of 0.25 Gm.

PARKE, DAVIS & COMPANY

DETROIT CAMPBELL P D & CO. WALKERVILLE

# This LIFE-LIKE Bardach-Schoene VACULIMB* ELIMINATES Shoulder or Waist SUSPENSION HARNESS



*The Stump should be dressed with Stockinet before using VACULIMB*

Action is instantly and accurately graduated in response to the degree of Stump operation by the patient.

A normal "feel" or reaction of the Stump allows the patient to sense the degree of application or release necessary to locomotion.

The controlling force of the Stump is rapidly transmitted to the VACULIMB, because of the close contact . . . no lost motion.



*Then Stump is placed in socket of VACULIMB in comfortable position*



*Next, Stockinet is drawn off Stump through Valve opening of VACULIMB . . .*



*Then adjustable Automatic Valve is inserted to seal opening of VACULIMB . . .*





*Finally, excess air is released by bearing body weight on VACULIMB.*

TO YOU, OUR FRIENDS, who have helped build this organization by your patronage, and to those whom we hope to serve in the future, we submit this most important development in the field of prosthetic appliances . . . The Bardach-Schoene VACULIMB!

While our VACULIMB is new to America's civilian use, it has a record of many years of successful use by thousands of amputees in Europe, in spite of extremely unfavorable manufacturing conditions. Because of this unique situation, the VACULIMB is undoubtedly the best "new" prosthesis ever announced to the Medical Profession, for the comfort and welfare of amputees.

An expert technician with long experience, trained in our organization in prosthetic work, will call at your convenience to demonstrate by actual test the amazing simplicity and accuracy of the new Bardach-Schoene VACULIMB . . . proving that it is sufficiently simple in operation for the amputee to justify its recommendation.

Our profession is like any other profession . . . progress and success in serving depends on the simple fundamental rule that each patient must be satisfied . . . our service is rendered throughout the life of the patient.

Close contact during many years with the Medical Profession, interested in the field of prosthetics, has been of great aid in gathering a wealth of important data, which is distributed by mail or direct contact upon request.

We welcome the opportunity to consult with the Medical Profession or Hospital concerning further details of our specialized service.

**NO EXTERNAL LEATHER STRAPS OR MECHANICAL MOVING PARTS TOUCH THE BODY**

# Bardach-Schoene Company, Inc.

**102 South Canal Street, CHICAGO 6, ILLINOIS**

*VACULIMB—Trade Mark Reg. U. S. Pat. Off.




*Available in bottles containing 15 cc. at most drug stores. For samples or further information, write:*

S. M. PHARMACEUTICALS

Division of Special Milk Products, Inc. • Los Angeles 64, California • Since 1934



*a* **new**
*antibacterial*
*agent...*

Wide antibacterial activity, low toxicity and virtual elimination of renal complications distinguish the use of Gantrisin* 'Roche', a new and remarkably soluble sulfonamide. Highly effective in urinary as well as systemic infections, Gantrisin does not require alkali therapy because it is soluble even in mildly acid urine. More than 20 articles in the recent literature attest its high therapeutic value and the low incidence of side-effects. Gantrisin is now available in 0.5 Gm tablets, as a syrup, and in ampuls. Additional information on request.

HOFFMANN-LA ROCHE INC • NUTLEY 10 • N. J.

**Gantrisin**®

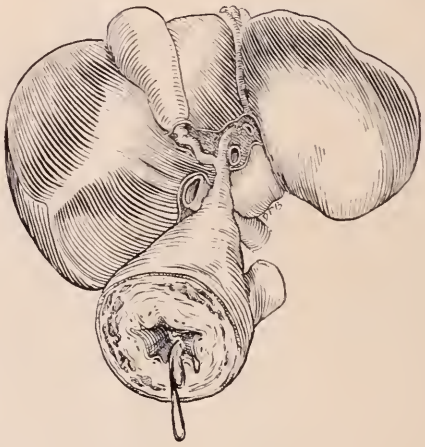
** Brand of sulfisoxazole (3,4-dimethyl-5-sulfanilamido-isoxazole)*

**'Roche'**

# *Physiologic*

## IN GALLBLADDER MANAGEMENT



**NUBILIC** represents the modern trend in the management of inflamed and congested gallbladder and bile ducts.

**NUBILIC** contains dehydrocholic acid, an efficient hydrocholeretic agent which thins the liver bile and flushes the biliary passages.

**NUBILIC** contains belladonna, which encourages free drainage and relaxes the sphincter of Oddi. This action is further enhanced by the central sedation of phenobarbital.

# NUBILIC

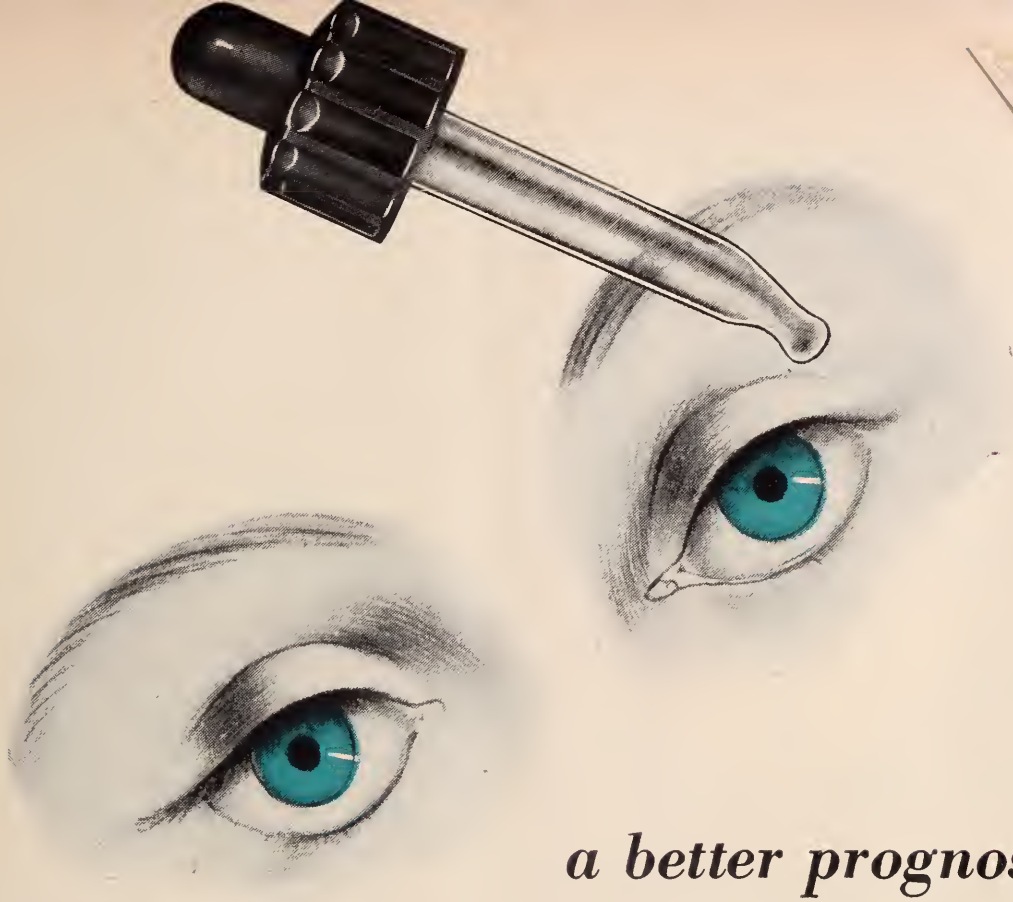
Each Nubilic Tablet contains:

| | |
|---|---|
| Dehydrocholic acid | 0.25 Gm. (3¾ gr.) |
| Phenobarbital | 8 mg. (⅛ gr.) |
| Belladonna | 8 mg. (⅛ gr.) |

Bottles of 25, 50 and 100 tablets

## NUMOTIZINE, Inc.

900 N. Franklin Street • Chicago 10, Illinois, U.S.A.



## *a better prognosis for the traumatized or infected eye*

Prompt instillation of SODIUM SULFACETIMIDE SOLUTION 30% following injury to the cornea or conjunctiva is a remarkably certain means of preventing ocular infection. "In 365 eyes in which a foreign body was removed . . . no infection occurred in any case."[1]

When treatment is started early, eye infections such as acute conjunctivitis may be cured within 36 hours.[2] Beneficial results have been obtained in 80 per cent of patients. In corneal ulcer the eye becomes practically normal in three or four days.[3]

# SODIUM SULFACETIMIDE SOLUTION 30%

(Sodium SULAMYD®)

In both the treatment and prophylaxis of eye infections, daytime therapy with SODIUM SULFACETIMIDE SOLUTION 30% is best supplemented by using SODIUM SULFACETIMIDE OPHTHALMIC OINTMENT 10%, applied at bedtime to maintain around-the-clock bacteriostasis.

**Dosage:** SODIUM SULFACETIMIDE SOLUTION 30%. One drop instilled in the eye every two to four hours depending on severity of infection or trauma.

**Packaging:** SODIUM SULFACETIMIDE SOLUTION 30% available in 15 cc. eye-dropper bottle. SODIUM SULFACETIMIDE OPHTHALMIC OINTMENT 10% in ⅛ oz. tubes.

**Bibliography:** 1. Mayer, L. L.: Arch. Ophth. *39*:232, 1948. 2. Kuhn, H. S.: Tr. Am. Acad. Ophth. (May-June) 1946, p. 210. 3. Wilkinson, O., in discussion of Mayer, L. L.: Arch. Ophth. *39*:232, 1948.

Schering CORPORATION
BLOOMFIELD, N. J.

SODIUM SULFACETIMIDE SOLUTION 30%

"The . . . estrogen preferred by us is 'Premarin,' a mixture of conjugated estrogens, the principal one of which is estrone sulfate."

Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

In treating the menopausal syndrome with "Premarin," Perloff* reports that "Ninety-five and eight tenths per cent of patients treated with 3.75 mg. or less daily obtained complete relief of symptoms"; also, "General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Thus, the sense of "well-being" usually imparted represents a "plus" in "Premarin" therapy which not only gratifies the patient but is conducive to a highly satisfactory patient-doctor relationship.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg. and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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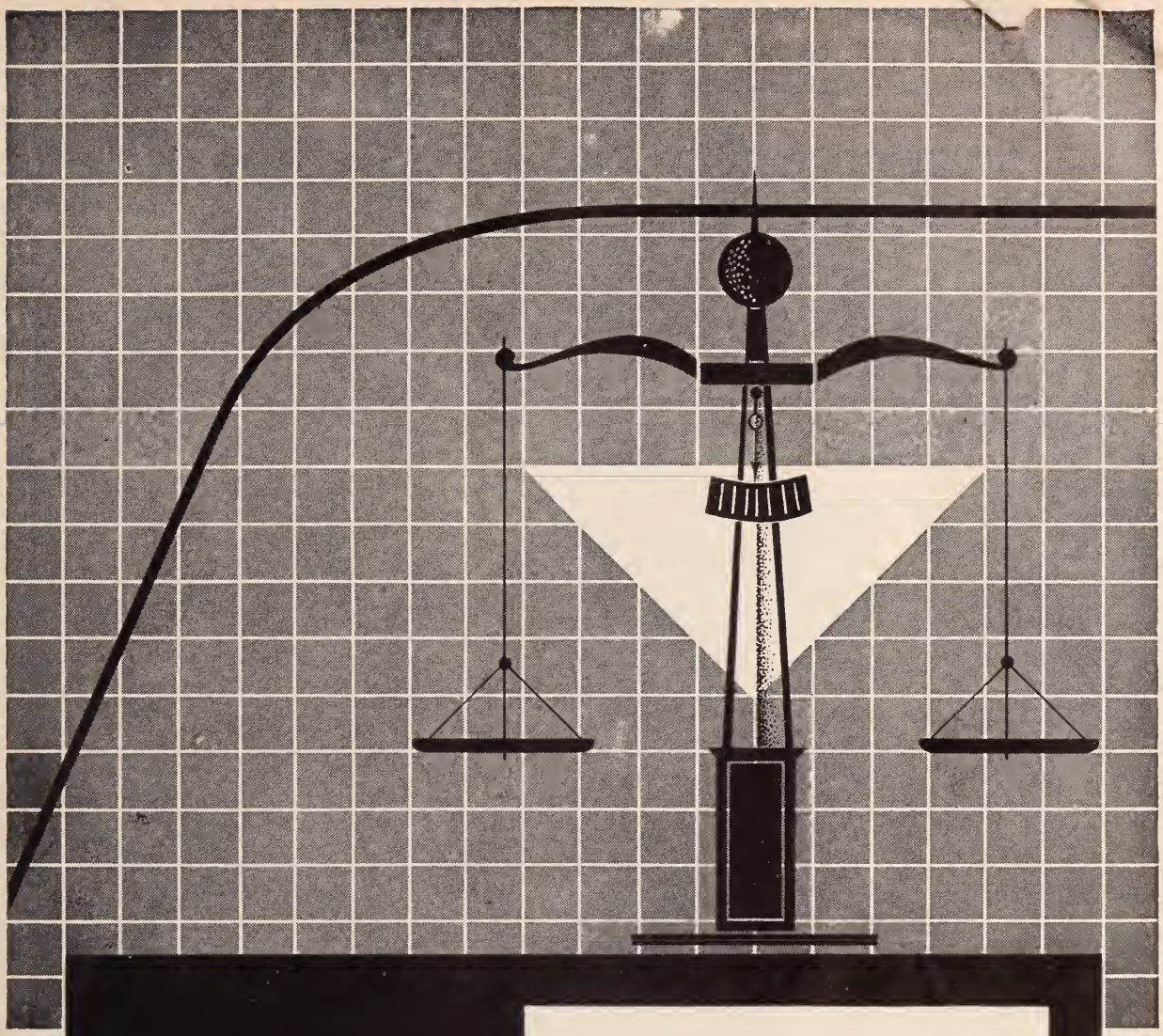
# "PREMARIN" ®

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

*Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine)*

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Prompt acting long lasting antacid therapy

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**SAFE — NO ACID REBOUND**

AMT is not absorbed. An adverse metabolic effect can not occur; no danger of alkalosis or acid rebound. Pleasant to take, too. No chalky feel.

# AMT*

## TABLETS

DRIED ALUMINUM HYDROXIDE GEL WITH MAGNESIUM TRISILICATE

For relief of temporary hyperacidity

*Two convenient sizes:*

Tins of 30; bottles of 100.

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*Wyeth* Incorporated • Philadelphia 3, Pa. *Wyeth*®

# *HERE AT LAST.....*

**the weapon you have always wanted in the control of hypertension**



# VERILOID*

*Product of Riker Research*

*A potent alkaloidal extract of Veratrum viride--biologically standardized for hypotensive activity in mammals--a new active principle not heretofore available, for the treatment of all forms of hypertension*

*TRADEMARK OF RIKER LABORATORIES, INC.

# IN EVERY FORM OF HYPERTENSION

## a new and more efficacious approach

Pharmacologic research covering three years, embracing more than 2000 individual animal experiments in mammals, and clinical studies including uninterrupted administration to a large group of patients for a full year have established the therapeutic efficacy of Veriloid.* Thus the achievement of isolating the active ester alkaloids of Veratrum viride has resulted in a distinct contribution to the management of hypertension.

● **AN ENTIRELY NEW DRUG.** Veriloid makes available for the first time the hypotensive ester alkaloids of Veratrum viride obtained by an exclusive extraction process which separates these active principles from inert material and less desirable alkaloids. The finished product represents, on a weight basis, less than one-tenth of one per cent of the crude drug from which it is derived.

● **A DEPENDABLE HYPOTENSIVE PRINCIPLE.** The hypotensive activity of Veriloid is predictable and dependable. The drug exerts a selective relaxing action on the smaller blood vessels, leading to their dilatation, hence to a drop in blood pressure.

● **UNIFORM POTENCY.** Biologic standardization of the purified extract in dogs, *using depression of the blood pressure as the end point*, insures absolute constancy of pharmacologic activity.

● **PROMPT, SUSTAINED CLINICAL EFFECT.** While individualization of dosage is essential for maximum therapeutic benefit, in the majority of patients the average dose of Veriloid—2.0 mg. to 5.0 mg. three or four times daily after meals and at bedtime—produces a sustained lowering of the arterial tension. The degree of drop usually results in marked subjective improvement. Veriloid is indicated in all forms of hypertension.

*Veriloid is available on prescription through all pharmacies in slow dissolving tablets containing 1.0 mg., in bottles of 100 and 200.*


***REFERENCES**

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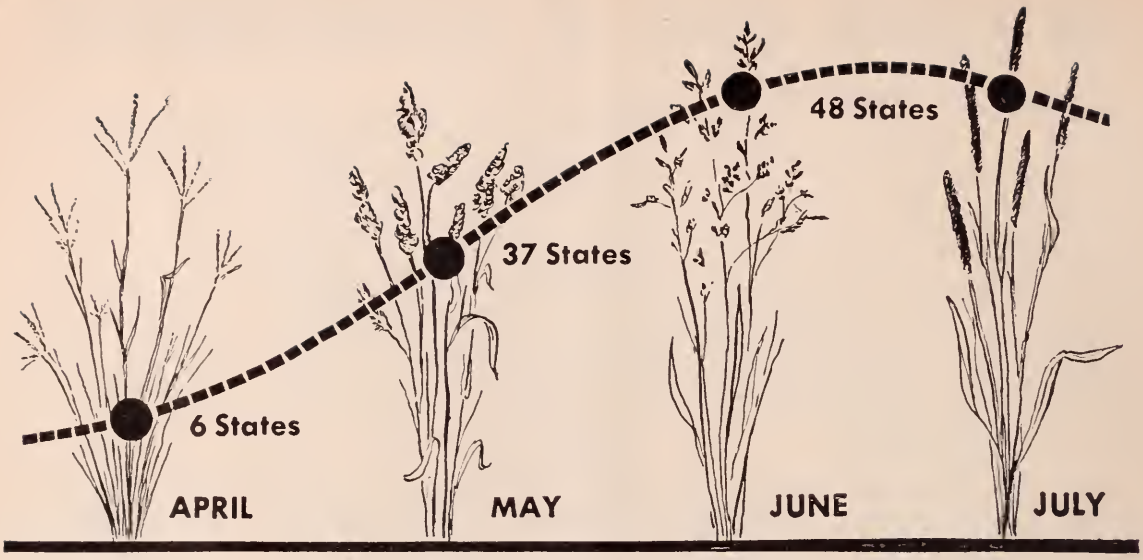
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**RIKER LABORATORIES, INC.**

8480 BEVERLY BOULEVARD

LOS ANGELES 54, CALIFORNIA




*This graph shows the number of States where hay fever, due to grass, prevails during the Spring and early Summer months.*

# *Dreaded Season...*

Many hay fever sufferers now are entering what is ordinarily their most uncomfortable season. Fortunately, more and more patients each year are enjoying the therapeutic benefits of Neo-Antergan® Maleate. Because of its safe and, in many cases, strikingly effective action in relieving the distressing symptoms of allergy—Neo-Antergan has become a favorite antihistaminic with physicians and patients.

Neo-Antergan is advertised exclusively to the medical profession. Your patients can secure its benefits *only through your prescription.*



Complete information concerning Neo-Antergan Maleate and its clinical uses will be sent on request.

MERCK & CO., INC.
*Manufacturing Chemists*
RAHWAY, NEW JERSEY

# Neo-Antergan®

MALEATE

(Brand of Pyranisamine Maleate)

(N-*p*-methoxybenzyl-N′, N′-dimethyl-N-*a*-pyridylethylenediamine maleate)

COUNCIL ACCEPTED



***depression*** causes . . .



***loss of appetite.*** which leads to . . .



***inadequate dietary intake***
and, consequently, to . . .



***B vitamin deficiency,***
resulting finally in . . .



***apathy, fatigue***
***and physical debility***

## to arrest the "downward spiral"

'Dexedrine'* plus essential B vitamins

# Theptine

## an antidepressant and nutrient elixir

Available in 12 fl. oz. bottles.

*Smith, Kline & French Laboratories • Philadelphia*

*'Theptine' and 'Dexedrine' are S.K.F. Trademarks

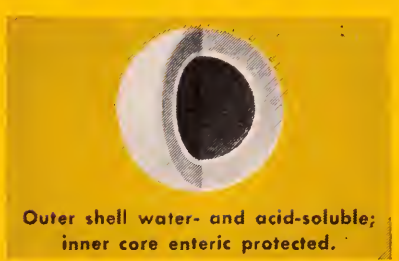
Each 5 cc. (1 teaspoonful) contains:
'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.), 2.5 mg.;
thiamine hydrochloride, 5.0 mg.; riboflavin, 0.45 mg.; niacin, 6.7 mg.

# Digestive Trouble-Shooter with "peptomatic" action*

Faced with complex digestive disturbances so frequently therapy-elusive, more and more physicians are utilizing Entozyme's highly effective triple-enzyme digestional aid in small-tablet form. Actually, a "tablet-within-a-tablet" (containing pancreatin, pepsin and bile salts), the secret of Entozyme's success lies in its unique "peptomatic" action*, which selectively deposits each digestive ferment at its proper gastro-intestinal level, in its optimal state of enzymatic activity. Entozyme's value has been well established clinically [1,2,3] in such conditions as chronic cholecystitis, chronic duodenal ulcer, acute and chronic pancreatitis and certain postoperative syndromes of the gastro-intestinal tract, as well as for the relief of functional disturbances such as nausea, pyrosis, belching, and flatulence.

*A coined word to describe the unique action of the Entozyme Tablet which releases pepsin *only* in the stomach, and pancreatin and bile salts *only* in the small intestine.

**A. H. ROBINS CO., INC., RICHMOND 20, VA.**
Ethical Pharmaceuticals of Merit since 1878



Outer shell water- and acid-soluble; inner core enteric protected.



Actually a "tablet-within-a-tablet."

Pepsin in outer shell released in stomach.



***Formula:*** Each specially constructed tablet contains Pancreatin, U.S.P., 300 mg.; Pepsin, N.F., 250 mg.; Bile Salts, 150 mg.

***Dosage:*** One or two tablets after each meal, or as directed by physician, without crushing or chewing.

***Supplied:*** Bottles of 25 and 100.

*References:* 1. Kammandel, N. et al.: Bull. New York Med. Coll., Flower & Fifth Ave. Hosps., (in press). 2. McGavack, T. H. and Klotz, S. D.: Bull. Flower & Fifth Ave. Hosp., 9:61, 1946. 3. Weissberg, J., McGavack, T. H. and Boyd, Linn J.: Am. Dig. Dis., 15:332, 1948.

Pancreatin and bile salts in inner core released in intestine.



# Entozyme®

***NOW AT LOWER COST: Entozyme has been reduced 33⅓% below the original list price.***

Robins

# Terramycin

Effective against a wide spectrum of bacterial, viral, rickettsial agents, and certain important protozoan organisms.

# Terramycin

is available in 250 mg.; 100 mg. and 50 mg. capsules. Dosage range—depending on the infection being treated—is from 2 to 3 grams daily in divided dosage.

***indicated for:*** *acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus and other Terramycin-sensitive organisms; brucellosis (abortus, melitensis, suis); hemophilus infections, including whooping cough (exclusive of meningitis); acute gonococcal infections; syphilis; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; herpes zoster; typhus (scrub, epidemic, murine); rickettsialpox; amebiasis (Endamoeba histolytica).*

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CHAS. PFIZER & CO., INC.
*Brooklyn 6, New York*

IN THE MANAGEMENT OF

*Diarrhea of Infancy*



"The ideal initial form of nourishment is apple powder . . . Its value lies in the fact that when administered in full dosage it enables the infant's digestive apparatus to tolerate and to utilize a high calory, high protein diet, provided the sugar content is kept low."[1]

# appella®

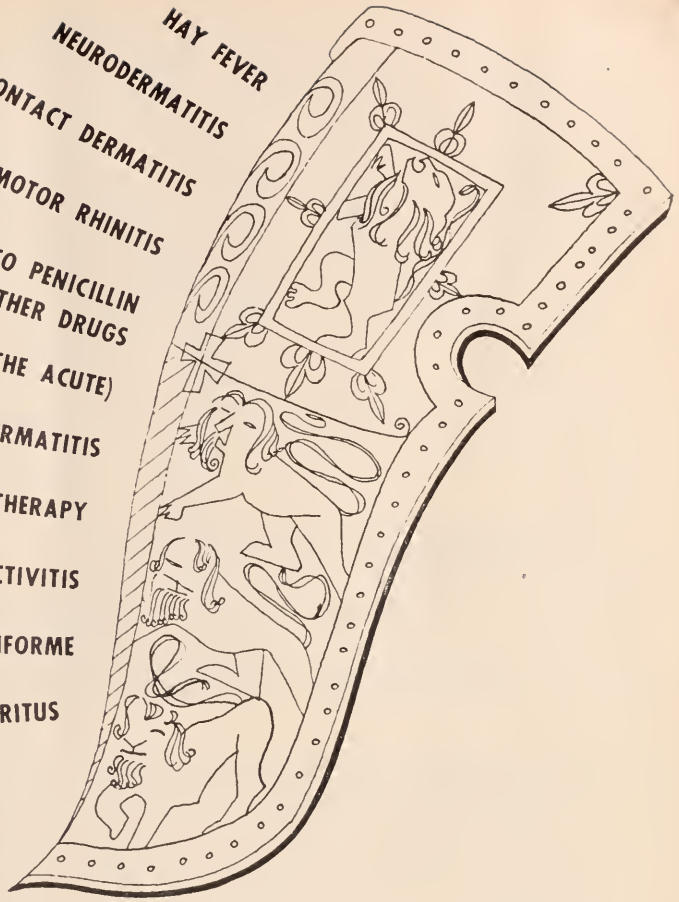
APPLE POWDER

**Prompt Control of Diarrhea · No Constipation · No Starvation**

Average dose 4 level teaspoonfuls three times daily. Make thick paste first, then gradually dilute to consistency of apple sauce. Feed from spoon or dilute further and administer through enlarged nipple opening. Supplied in 7 oz. and 18 oz. jars.

*Winthrop-Stearns* INC.
NEW YORK 13, N. Y. WINDSOR, ONT.

1. O'Keefe, E. S.: *Am. Jour. Dis. Child.*, 76:616, Dec., 1948.




# A Shield Against Allergic Disorders

# DIATRIN* Hydrochloride

*'WARNER'*

## A Superior Antihistaminic of Proved Value [1,2,3]

## Effective · Less Toxic · Minimum Side-Effects

**PACKAGE INFORMATION:** Diatrin* Hydrochloride sugar-coated oral tablets, 50 mg each; bottles of 100 and 1000 tablets.

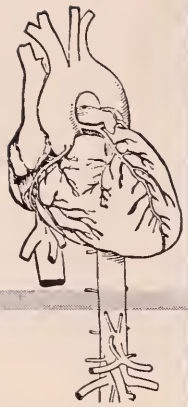
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*T. M. Reg. U. S. Pat. Off. **WILLIAM R. WARNER & CO., INC.** New York, St. Louis



# 400% more cholesterol in coronary arteries

## postmortem studies reveal 4 times greater cholesterol content of coronary arteries in fatal coronary thrombosis[1]

"The average cholesterol content of the coronary arteries in a group of patients who died from an acute coronary artery thrombosis was four times as great as the average cholesterol content of the coronary arteries in a comparable group of control patients."

"Hypercholesterolemia was found in most of the patients who died of acute coronary artery thrombosis, as compared to a normal blood cholesterol average in the comparable control group."[1]

Accumulating evidence shows that lipotropic therapy will reduce elevated blood cholesterol levels[2,3,4] . . . and even may "prevent or mitigate" cholesterol depositions in the intima of blood vessels in man and animals.

It has already been reported that in patients who have had acute coronary occlusion, lipotropic therapy may significantly prolong life over an untreated group with the same diagnosis.[5]

a complete lipotropic formula

# methischol®

suggested daily therapeutic dose of 9 capsules or 3 tablespoonfuls provides:

| | |
|---|---|
| Choline Dihydrogen Citrate | 2.5 Gm.* |
| dl-Methionine | 1.0 Gm. |
| Inositol | 0.75 Gm. |
| Liver fractions from | 36.0 Gm. liver |

*present in Methischol Syrup as 1.15 Gm. choline chloride.

supplied in bottles of 100, 250, 500 and 1000 capsules, and 16 oz. and 1 gallon syrup

write for samples and literature

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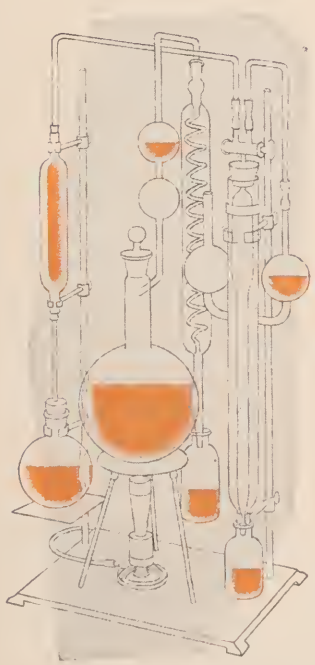
Casimir Funk Labs., Inc. (affiliate) • 250 East 43rd St. • New York 17, N. Y.


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5. Morrison, L. and Gonzalez, W. F.: Amer. Heart J. 38:471, Sept. 1949.

# AUREO-MYCIN

*in Surgical and Other Infections*

## AUREOMYCIN



Surgeons are now generally coming to the conclusion that the use of aureomycin preoperatively and postoperatively in all cases is worthwhile insurance against infection. This is particularly true in infections involving the peritoneum.

Aureomycin has also been found effective for the control of the following infections: African tick-bite fever, acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, tularemia and typhus.

**Capsules:** Bottles of 25, 50 mg. each capsule.
Bottles of 16, 250 mg. each capsule.

**Ophthalmic:** Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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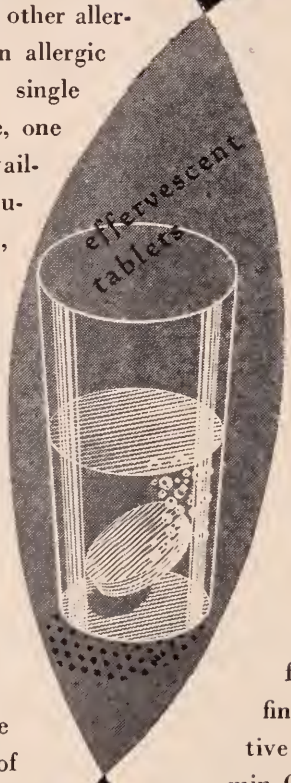
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Trade Marks—Cehistra and Vistora



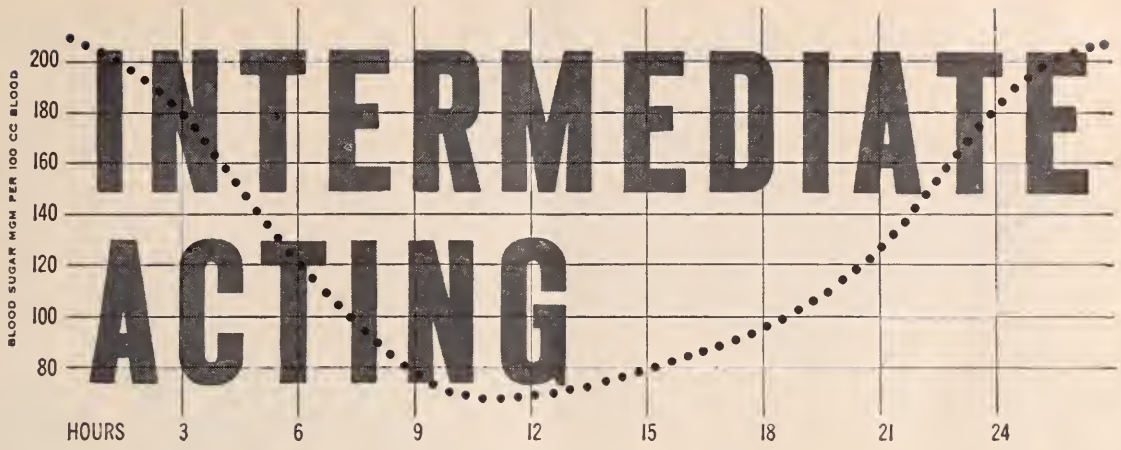

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**IN 1939,** Reiner, Searle and Lang described a new "intermediate acting" insulin.

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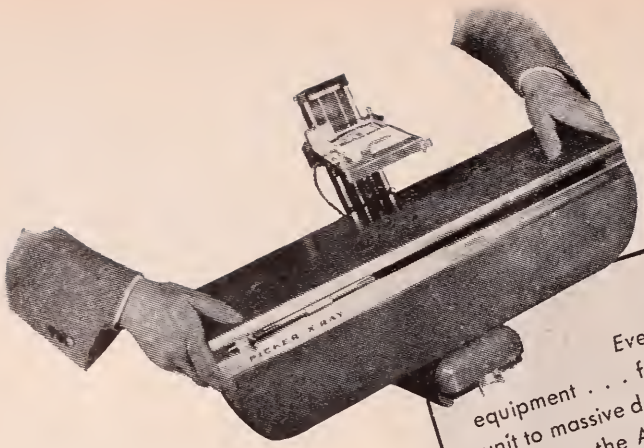
*In 10 cc. vials, U-40 and U-80.*




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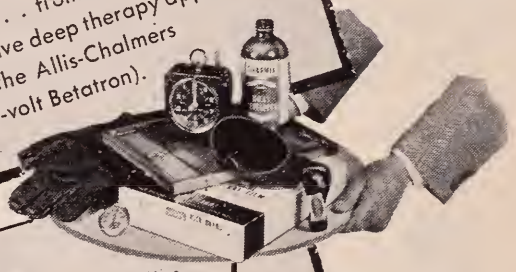
1. Rohr, J.H., and Colwell, A.R.: Arch. Int. Med. 82:54, 1948.
2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.

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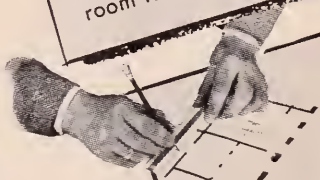
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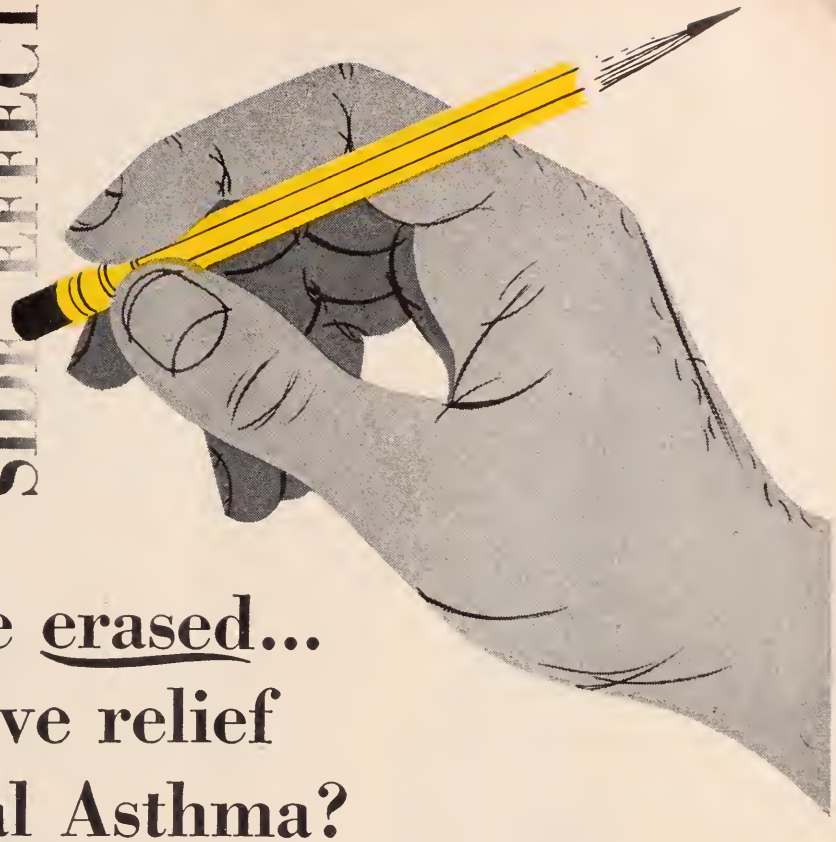
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Each 5 cc. or capsule contains: Nethamine® Hydrochloride 25 mg., Butaphyllamine® 60 mg., Decapryn® Succinate 6 mg.

When Phenobarbital is preferred to the antihistamine, prescribe NETHAPHYL®—in convenient capsules. In regular or half strength.

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1828
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[1]Hansel, F.K.: Ann. Allergy, 5:397, 1947

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**the standard forms of iron therapy**




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*A 19" x 12" reproduction of this illustration by Peter Helck is available upon request.*

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Long before Grandpa's spring purges with sulfur and molasses, the yellow powder was famous in medicine. Hippocrates claimed that it protected from plague; the *Odyssey* mentions that burning it purified the air.

Elemental sulfur's importance as a treatment for various skin conditions is now overshadowed by its use in modern complex chemical compounds. To sulfur, the sulfa drugs owe an essential part of their basic structure. The mercury-sulfur linkage accounts in part for the merit of 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly).

Other compounds in which sulfur is present in a significant functional group are being studied in the Lilly Research Laboratories. From unceasing effort in this and many other fields of chemical research, better pharmaceuticals continue to emerge.

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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 98, No. 1 July, 1950

## THE SPRINGFIELD MEETING

The 1950 annual meeting held in Springfield May 23-25, was well attended, well arranged and all present were apparently of the opinion that this was truly another highly successful meeting. For the first time it was possible to have all exhibits, general assembly sessions and the motion pictures in the same building at a meeting outside of Chicago. The Illinois National Guard Armory, one of the largest buildings in the state, is indeed well adapted for meetings of this type.

The Sangamon County Medical Society, acting as the official host society, went all out to plan everything locally for the enjoyment and best interests of the members and others who attended the meeting. Dr. Jacob E. Reisch, as general chairman of the Committee on Arrangements, devoted the major part of his time over a period of weeks prior to the meeting to see that everything was in proper order.

All hotel reservations were made by the Convention Bureau of the Chamber of Commerce and the executive officer, Mr. Oscar Ansell likewise devoted a large amount of time to see that all applications were cared for. Likewise he was on duty throughout the meeting to take care of the needs of late comers without reservations.

It was interesting to note that more scientific exhibits were shown at this meeting than ever before at any annual meeting of the Society. Dr. Coye C. Mason and his Committee on Scientific Exhibits were in charge. Several of the scientific exhibits at our meeting will be entered in the scientific exhibit of the American Medical Association in San Francisco.

The meetings of the House of Delegates were held at the Hotel Abraham Lincoln where ample accommodations were available. As has been the custom in this Society, the President acted as the presiding officer at the meetings of the House. Walter Stevenson, as President, performed this duty in a highly satisfactory manner.

The annual dinner on Wednesday evening was attended by more than 500, the maximum number which could be accommodated. The speaker of the evening was Mr. Raymond Moley, a member of the editorial staff of *Newsweek*, whose subject was "Freedom or Socialism — Which?" Following this fine address, the presentation of the President's Certificate was made by the chairman of the Council, Dr. Oscar Hawkinson.

The 1950 annual meeting had been designated "The Andy Hall Meeting". Doctor Hall was at the annual dinner and was presented with the Outstanding General Practitioner Award by the president, Doctor Stevenson. Two of Doctor Hall's physician sons were present on the occasion, the third being unable to attend.

At the second session of the House of Dele-

gates the following were elected as officers, councilors and delegates and alternates to the American Medical Association.

President: Harry M. Hedge, Chicago

President-Elect: C. Paul White, Kewanee

1st Vice President: Jacob E. Reisch, Springfield

2nd Vice President: A. J. Linowiecki, Chicago

Secretary-Treasurer: Harold M. Camp, Monmouth

Councilors:

1st District: Joseph S. Lundholm, Rockford

2nd District: Joseph T. O'Neill, Ottawa

3rd District: Leo P. A. Sweeney, Chicago
F. Lee Stone, Chicago
Wade C. Harker, Chicago

11th District: Edwin S. Hamilton, Kankakee

Delegates and Alternates to the A.M.A.

PERCY E. HOPKINS, Chicago
Willard O. Thompson, Chicago

WARREN W. FUREY, Chicago
Karl L. Vehe, Chicago

CHARLES H. PHIFER, Chicago
G. Henry Mundt, Chicago

ROBERT H. HAYES, Chicago
H. Kenneth Scatliff, Chicago

FRED H. MULLER, Chicago
Eugene T. McEnery, Chicago

BERNARD KLEIN, Joliet
James E. Wheeler, Belleville

WILLIS I. LEWIS, Herrin
K. B. Reiger, Freeport

MATHER PFEIFFENBERGER, Alton
Irving H. Neece, Decatur

HARLAN ENGLISH, Danville
L. S. Reavley, Sterling

EVERETT P. COLEMAN, Canton
Edwin H. Weld, Rockford

The total registration at the Springfield meeting was not so large as registrations at recent Chicago meetings, however it was generally considered a good meeting. The registration shows:

| | |
|---|---|
| Physicians | 1,026 |
| Guests | 463 |
| Commercial exhibitors | 166 |
| Woman's Auxiliary | 426 |
| Illinois Heart Assn. | 28 |
| | 2,109 |

Many excellent presentations were made before the general assembly sessions and likewise at individual section meetings. Some of these fine papers will be published in the Illinois Medical Journal in the near future.

At the closing session of the House of Delegates it was voted to ask the Council to select the meeting place for 1951. At a meeting of the Council held June 4, it was decided that the next annual meeting will be held in Chicago in May, 1951. The exact place and time will be announced in the near future, following the necessary investigations ordered by the Council.

Much credit must be given to the Sangamon County Medical Society, the press of Springfield, city officials, and many others for the fine spirit of cooperation which was invariably manifest in making this a highly successful annual meeting. This too, was well exemplified in the fine cooperation received from the members of the National Guard Personnel, and especially the custodian, Mr. Frank Devaney.

## THE TREATMENT OF MIGRAINE

In the May issue of Postgraduate Medicine there is a short but excellent review on migraine headache by Drs. Robert M. Marcussen and Harold G. Wolff. In the discussion on treatment, six sentences were allotted to describe the use of ergotamine tartrate and Dihydroergotamine (DHE 45) for relief of pain. Eight times this amount of space was given to the psychogenic aspects of the disorder along with specific instructions on work, worry, exercise and readjustment to the environment. We are in hearty agreement with the authors' allotment of space concerning the relative importance of drugs versus common sense instruction and believe that the latter is eight times as important so far as the ultimate control of this type of headache is concerned.

We wonder how often instruction along this line is neglected by the physician. Experience has taught him that the patient is more interested in medicine and prefers a pill or capsule to changing his way of life. It is well known that with obesity, the individual would pay anything for a magic tablet rather than a diet to help him lose weight. The same situation exists among those with migraine but the victims are driving persons who are rigid, ambitious and perfectionistic. When they become tense, tired or exhausted, headache is most likely to make its appearance. Cure is difficult but the closest ap-

proach can be accomplished by changing their habits of living and thinking.

According to the authors, the migraine addict must cut down on the number of activities and chores ordinarily done in a day and must learn to be less fussy about minor details. Time should be allowed for adequate rest. "Fun and a pleasant sence of tiredness—not exhaustion—are the goals." They also suggest avoiding needless and useless worry and a change of ideals and standards to fit in better with everyday experiences. Learning to develop a fuller tolerance of others is important. In this way they learn to understand their companions and co-workers better and are less likely to become resentful. All of this brings a feeling of relief and new enjoyment of life.

It takes time to change the personality but the transformation will cure many ailments. This is our job and as soon as the patient is convinced there is more to medicine than tablets and capsules the easier our job will be.

## NEW POSSIBILITIES FOR VITAMIN $B_{12}$

Vitamin $B_{12}$ is just beginning to make a dent in the science of clinical and human nutrition. There is no doubt about the potency of the product and some of its actions in this field are almost as startling as those of ACTH and Cortisone on the rheumatic diseases.

Vitamin $B_{12}$ is one of the most powerful known materials which is active against pernicious anemia, sprue, and other macrocytic anemias. Physiological studies have shown that it also acts as a stimulant to fat metabolism. Drill and McCormick[1] administered a concentrate of Vitamin $B_{12}$ in small quantities to rats receiving a high fat diet (lard 51%) over a period of twenty-nine to sixty-six days. There was a significant lipotropic effect in that the fat of the liver was only about half as high as the expected increase in liver fat which occurs when the $B_{12}$ is omitted. The results were the same as those obtained in control animals who were on a normal diet containing only 6% lard.

The results with $B_{12}$ were comparable to those in previous studies with liver extract. Choline and methionine were given credit in those previous studies and although these substances are present in $B_{12}$ the amount is insufficient to restore the livers to normal. This means that many of the effects of choline particularly may be due to $B_{12}$. This research opens up an entire new field of work in liver disease and conditions such as diabetes, hypothyroidism and atherosclerosis in which excess fat accumulation is thought to play a role. $B_{12}$ is a trace vitamin in some foods. It is most prevalent in fish solubles, streptomycin slops, and sheep rumen. According to Lewis and his co-workers from the University of Wisconsin,[2] foods rich in this substance include glandular meats such as liver and kidney, with lesser amounts in muscle tissue, cheese, eggs and milk. Plant materials are practically devoid of $B_{12}$.

(1). Victor A. Drill and Harry M. McCormick, from the Department of Physiology and Pharmacology, Wayne University College of Medicine, Detroit, Mich.

(2). U. J. Lewis, U. D. Register, H. T. Thompson and C. A. Elvehjem, from the Department of Biochemistry, College of Agriculture, University of Wisconsin, Madison.

## THE 1950 SCIENTIFIC EXHIBIT AWARDS

At the 1950 annual meeting held in Springfield May 23-25, there were more scientific exhibits than had ever previously been displayed at an annual meeting of the Society. Consequently, the committee on awards had a more difficult task before them, when they viewed all exhibits then selected those which were most outstanding in their respective class. The awards were made as follows:

FOR EDUCATIONAL VALUE

*GOLD MEDAL*

Carcinoma of the Breast: Diagnosis and Selection of Treatment." Exhibitor: Louis River, Joseph Silverstein. Institution: Hektoen Institute, Cook County Hospital, Stritch Medical School of Loyola University and the Doctor Jerome D. Solomon Memorial Research Foundation.

*SILVER MEDAL*

"Appendicitis" Exhibitor: Warren H. Cole, William Requarth, Gloria Kenney. Institution: University of Illinois College of Medicine.

*BRONZE MEDAL*

"Stereoscopic Kodachrome Transparancies of Diseases of the Fundus Oculi". Exhibitor: Peter C. Kronfeld, Glen Ford. Institution: Illinois Eye and Ear Infirmary of the University of Illinois.

*BRONZE MEDAL*

"Multiple Myeloma". Exhibitor: Carroll

L. Birch, Louis R. Limarzi, P. L. Bedinger, Raymond S. Kibler. Institution: University of Illinois, College of Medicine.

*BRONZE MEDAL*

"Carcinoma of the Colon and Rectum". Exhibitor: James Graham, Arthur Lindsay, James Cunningham. Institution: Springfield Clinic.
FOR ORIGINAL WARK

*GOLD MEDAL*

"Quantitative Studies on the Mechanisms of Gastric Secretion." Exhibitor: Lester R. Dragstedt, Edward R. Woodward, Edward H. Storer, Harry A. Oberhelman, Jr., Curtis A. Smith. Institution: Department of Surgery, University of Chicago.

*SILVER MEDAL*

"Management of Injuries to Spinal Cord and Cauda Equina." Exhibitor: Lewis J. Pollock, Benjamin Boshes, Herman Chor, Isidore Finkelman, Meyer Brown, Alex J. Arieff, Joseph G. Kostubala, Louis B. Newman. Institution: U. S. Veterans Administration Hospital, Northwestern Univ. Medical School.

*BRONZE MEDAL*

"Treatment of Tuberculous Laryngitis by Chemotherapy." Exhibitor: Linden J. Walner, George C. Turner, Meyer Lichtenstein, and Henry C. Sweeney. Institution: Municipal Tuberculosis Sanitarium, Veterans' Hospital, Hines, University of Illinois.

*BRONZE MEDAL*

"Radioactive Iodine: Its Use in Diagnosis and Therapy." Exhibitor: D. E. Clark, O. H. Trippel, G. E. Sheline, M. C. Moore. Institution: University of Chicago.

*BRONZE MEDAL*

"Treatment of Intracranial Aneurysm." Exhibitor: Harold C. Voris. Institution: Stritch School of Medicine, Loyola University.

## ANDY HALL RECEIVES ALUMNI MEDAL

Andy Hall of Mt. Vernon, the Outstanding General Practitioner of the nation for 1950, was honored by Northwestern University on Alumni Day, June 10, 1950; having been awarded the Alumni Medal presented only to alumni who have been outstanding over a period of years. The medal and citation are presented to distinguished alumni of Northwestern University and Dr. Hall is one of few who have received this signal honor. He graduated from the Northwestern University Medical School in 1890, and has completed sixty years of service to his patients at Mt. Vernon, his only location during this long period.

Now in his eighty-sixth year, Dr. Hall can be found at his office every day when he is at home, and during the past year his visits throughout Illinois and into many other states, have changed his regular routine most materially. He has appeared before many state and county medical societies, dozens of luncheon and dinner clubs, and before many other types of organizations to discuss current medical progress, and give his opinion of the proposed socio-economic changes in our American Way of Life.

Yet with the unusual honors which have been given him in recent months, he is still the same patient family doctor to many hundreds of grateful patients, and "Andy" to his thousands of friends in and out of the medical profession. He makes frequent trips to various parts of Illinois to present the official emblem and certificate to candidates for membership in the Illinois State Medical Society FIFTY YEAR CLUB, of which he has been the only chairman since its development some thirteen years ago.

So once more, Northwestern University has given a well deserved honor to a man who is truly worthy of this, and other honors which have been given to him during the past year.

# CORRESPONDENCE




## FREE DRESSINGS FOR CANCER PATIENTS

The Illinois Division of the American Cancer Society is prepared to furnish dressings in any quantity needed to cancer patients being cared for in their homes. These dressings, clean but not sterile, are made in various sizes of cellucotton covered with soft, worn, white cotton materials.

Physicians wishing this service for their cancer patients may apply to the service chairman of the local chapter of the American Cancer Society or to the office of the Illinois Division, 139 North Clark Street, Chicago 2, Illinois.

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR AUGUST

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the August schedule of clinics for physically handicapped children. The Division will conduct 11 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The August clinics are:

August 8—E. St. Louis, Christian Welfare Hospital
August 8—Peoria, St. Francis Hospital
August 9—Hinsdale, Hinsdale Sanitarium
August 10—Springfield, St. John's Hospital
August 10—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
August 10—Macomb, St. Francis Hospital
August 10—Chicago Heights (Cerebral Palsy), St. James Hospital
August 11—Chicago Heights (Rheumatic Fever), St. James Hospital
August 15—Effingham, St. Anthony's Emergency Hospital
August 16—Springfield (Cerebral Palsy), Memorial Hospital
August 16—Aurora, Copley Hospital
August 17—Rockford, St. Anthony's Hospital
August 22—Peoria, St. Francis Hospital
August 23—Chicago Heights, St. James Hospital
August 24—Normal, Brokaw Hospital
August 25—Chicago Heights (Rheumatic Fever), St. James Hospital
August 29—Effingham (Rheumatic Fever), St. Anthony's Emergency Hospital

# ORIGINAL ARTICLES



# Treatment of Peripheral Vascular Disorders

**Harris B. Shumacker, Jr., M.D.,**
**Indianapolis, Indiana**

It is my purpose to discuss some of the general problems which are of importance in the treatment of disorders of the peripheral circulation. I shall try to point out those limiting factors which prevent us from achieving the universal success we should all desire, to call attention to the assets which enable us to render reasonably effective service, and to mention certain features of treatment which seem to me of particular importance.

The limitations stem largely from our lack of knowledge of the etiology of some of the most important peripheral vascular diseases, from our general inability to prevent their occurrence, from the diffuse nature and progressive character of many of them and from the irreparable damage which often accompanies the disease process. It goes without saying that prevention is far better than any treatment. We should be little concerned if the treatment of any given disorder should remain generally unsatisfactory provided reasonable means should become available to prevent its development. For example, in spite of all the advances which have been made, the treatment of tetanus remains a very real problem and the mortality shockingly high. Yet it would be safe to say that tetanus should virtually disappear as a clinical problem if active immunization with toxoid were universally applied. It is unfortunate that such is not the case with the commonest and gravest of the peripheral vascular disorders. We know practically nothing about the etiology of such conditions as arteriosclerosis, thromboangiitis obliterans, Raynaud's disease and most of the other vasospastic conditions, and we are powerless to prevent them. Indeed, as the life span of man is gradually extended, those disorders of advanced years, such as the obliterative arterial diseases, become increasingly prevalent.

Treatment is obviously rendered more difficult when one is dealing with a progressive and diffuse disease such as peripheral arteriosclerosis or Buerger's disease. Here one can never be satisfied with even a gratifying solution of the

**From the Department of Surgery, the Indiana University Medical Center, Indianapolis, Indiana. Read at the one hundred ninth annual meeting of the Illinois State Medical Society, Chicago, Illinois, May 16-18, 1949.**

immediate problem but must be concerned with the possible future extension of the obliterative process and the development of new difficulties. It must be recognized, too, that irreparable damage accompanies some of the disorders; the artery occluded by obliterative disease and the vein closed with thrombus are forever incapable of proper function. The insidious nature of some the disorders is another factor which limits our ability to cope adequatcly with them. All too often symptoms develop so quietly and progress so gradually that the patient consults his physician for the first time when the affected limb is on the verge of gangrene. Of further importance is the general lack of awareness of the importance of symptoms resulting from the disordered peripheral circulation. It is a rare person who does not seek aid with his first episode of precordial pain, but far too frequently coldness or numbness of digits, abnormal color changes, rest pain or intermittent claudication go unheeded until disaster is imminent. The same failure to appreciate the gravity of the situation applies to treatment. No one who has treated Buerger's disease can fail to have been impressed with the difficulty of convincing the patient of the importance of such measures as cessation of smoking.

On the other side of the ledger may be listed a number of real assets in the treatment of the peripheral vasular disorders. In the first place, though we may know nothing fundamental about the etiology and may be completely incapable of preventing the occurrence of certain of these diseases, we are still often able to reduce the likelihood of development of the more serious accompaniments, complications and sequelae. There can be no doubt that the incidence of fatal pulmonary emboli can be decreased by judicious use of such measures as proximal vein interruption and anticoagulant therapy in acute venous thrombosis. It also seems evident that the chance of development of the post-phlebitic state with its likelihood of distressing pain, pigmentation, dermatitis, edema, induration and ulceration can be diminished by proper intensive treatment of the acute thrombotic difficulties and subsequent careful graded rehabilitation with proper stress on the use of elastic support, periodic rest and elevation of the affected extremity until prolonged unsupported dependency is possible without the occurrence of edema or pain. The numerous major amputations in patients with diabetes, arteriosclerosis and Buerger's disease necessitated by gangrenous or infections processes beginning in neglected callouses or blisters, fissures, ingrowing toenails, etc. bear witness to the necessity for the most painstaking care of skin and nails in such disorders.

In the second place, diagnosis should offer no particular difficulty if the problem is approached intelligently and carefully. There are, to be sure, exceptions which tax the ingenuity of the specialist, but, by and large, the various disorders should be recognized with relative ease. It is fortunate, too, that no elaborate or expensive equipment is ordinarly required. A carefully taken history and a well-done vascular examination utilizing no apparatus other than the simple gadgets available to every doctor — stethoscope, ophthalmoscope, sphygmomanometer, rubber tourniquet, syringe and needles — usually suffice not only to establish the correct diagnosis but also to permit a valid outline of treatment. It is fortunate, too, that for the less common, more difficult problems there are available a number of instruments and tests which permit more precise evaluation of the peripheral circulation and of its component parts. Among these additional studies may be mentioned the various tests for circulation time, thermocouple determination of skin temperature, oscillometry, angiography, digital plethysmography, venous occlusion plethysomography and some of the newer applications of radioactive isotopes. It should be emphasized that these measures are of more value in accumulating objective data in an effort to advance our knowledge of the circulatory disorders and of means of treating them than for the general sorting out of the various conditions and for their intelligent management.

In the third place, very useful techniques of treatment have been developed. There are available reasonably safe and effective means of inducing an anticoagulant effect and of reducing the chance of intravascular clotting. A good bit is known of drugs which tend to produce general vasodilatation as well as of physical methods which induce reflex vasodilatation. There are effective methods for producing local vasodilatation to a part, temporarily through somatic nerve block and still more effectively through sympa-

thetic nerve block, and more or less permanently through operative sympathetic denervation. Safe and adequate operative exposure of the various peripheral vessels is possible. Methods have been developed for their ligation and division, for closing rents in them by suture, for anastamosing their cut ends, for bridging defects by interposing free vascular transplants, and for treating surgically such localized lesions as emboli, aneurysms and arteriovenous fistulas. Finally, for those cases requiring amputation, suitable prostheses may be obtained.

I cannot help but feel that careful attention to certain details will do much to bring about improved results in the treatment of the various peripheral vascular disorders. The basis for good treatment is the obtaining of an accurate history and the performance of a good examination. It cannot be emphasized too strongly how important it is that every history and physical examination should include an inquiry into the cardiovascular system and that such observations be entered into the patient's record. In the case of an absent dorsal pedal pulse the correct differentiation between early obliterative disease and a harmless congenital anomaly may be virtually impossible unless one knows whether the absent pulsation is a recent development or not. The general practitioner who sees his patients over a period of many years has a rare opportunity to provide himself with information which may some day be of extreme value in the recognition and treatment of a vascular disorder, or in evaluation of its progress.

Of great importance is the early diagnosis and treatment of the peripheral vascular disorders. It has long been proved that cases of major arterial embolism treated by embolectomy within a few hours have an excellent prospect of restitution of normal circulation — an outlook which may be utterly hopeless after a delay of some additional hours. The recognition and treatment of varicose veins before complications occur may avert the most annoying and incapacitating sequelae. The prompt recognition and treatment of phlebothrombosis may prevent a fatal embolism.

It is mandatory that the care of patients should include attention to the smallest details. We cannot assume that the patient with obliterative disease knows how to trim his toenails and the importance of such care in preventing ingrowing nails. He must be told that the application of local heat may not be the correct thing even if his foot feels cold. He must be shown how to inspect his feet daily for fissures, callouses and blisters. He must be given specific directions for any measures recommended such as Buerger's exercises, contrast baths, etc.

We must recognize the limitations of treatment. For example, rational treatment of severe elephantiasis is based on the knowledge that such disorders develop because the entire lymphatic return is blocked totally or almost totally and that up to the present time, we have no means of re-establishing lymphatic return in such cases. Only then does the application of the Homan's type of procedure become understandable with its excision in stages of those subcutaneous tissues in which the fluid tends to accumulate. No matter how disheartening it may be, we must recognize the necessity for amputation once extensive gangrene is present. To delay in vain hope only adds to the patient's incapacity and expense. Conversely, we must not resort to amputation for pain alone, but must make use of all those measures which have obviated this necessity.

If it is important to be familiar with defeat, so to speak, it is equally important that every effort be made to conserve maximum function. The problem of major amputation serves as a useful example. Some years ago, thigh amputation was more or less the routine procedure for cases of gangrene due to obliterative disease. Satisfactory as low thigh amputations are, however, preservation of the knee adds considerably to the case of locomotion once a prosthesis is applied and it is now evident that satisfactory healing of amputations below the knee is often possible if one assays the circulatory status carefully and uses all measures to prevent infection. An amputee who does not use a prosthesis is comparatively crippled, his care is often troublesome and he is not apt to be a self-supporting or self-respecting member of society. This is not the case with the amputee who uses well a properly fitted prosthesis. The percentage of patients using prosthesis will depend more on the surgeon's persuasion than on the patient's general state of vigor or debility. Such persuasion should start, indeed, before the amputation is performed and, if possible, a temporary prosthesis should be applied early and worn until

the stump is ready for use of a permanent prosthesis. Similarly, a few understanding, kindly words about the customary temporary physiological sensations of the phantom limb before operation and in the early postoperative course will generally avert the development of that disheartening and often incurable syndrome, phantom limb pain.

Finally, we must follow the principle that each patient deserves that treatment which, in the light of current knowledge, seems most effective — not that treatment in which we happen to have an especial interest or which we are particularly equipped to dispense. The surgeon has no justification in omitting any established non-operative measures. The physician cannot justifiably substitute less effective medicinal or physiotheraputic measures if a surgical procedure yields superior results. The treatment of the peripheral vascular disorders entails alertness, patience and the most intelligent and painstaking care. The harvest admittedly includes the most tragic disappointments but it also includes many gratifying rewards.

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# Observations on the Use of Aureomycin in the Treatment of Acute Anterior Poliomyelitis

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**Waukegan**

During the 1949 polio epidemic there were 52 cases of acute poliomyelitis admitted to St. Therese Hospital, Waukegan, Illinois. We became interested in observing the effect of aureomycin on the clinical picture as well as on the final outcome of the disease. The reason for selecting aureomycin for our clinical experiment was the fact that only aureomycin had been shown to be effective in some virus infections while no other antibiotic had proved of any beneficial effect whatsoever in any viral disease.

Each of the attending physicians at St. Therese Hospital was required to use aureomycin in addition to any other method he chose to use for the treatment of his cases of poliomyelitis. Each record was carefully studied and the data analyzed. No case is included without at least a history of fever, headache, backache, stiff neck or pain in the limbs. Physical examination must have revealed some signs of central nervous system involvement, such as neck rigidity, loss of abdominal or cremasteric reflexes, abnormal tendon reflexes or definite paralysis. Pleocytosis of the cerebro-spinal fluid was considered as further confirmatory evidence of the disease. A few cases which did not meet these criteria were omitted from this study. Of the remaining 52 cases there were 27 males and 25 females which further confirms the known fact that there is no difference in distribution between the sexes.

TABLE 1

Distribution according to Age:

| | |
|---|---|
| 0- 5 years | 8 |
| 6-10 years | 16 |
| 11-15 years | 8 |
| 16-20 years | 9 |
| 21-30 years | 6 |
| 31 and over | 5 |

From Table 1 it is evident that the disease can no longer be correctly named infantile paralysis, since more than 50% of the cases were over 10 years of age and almost 30% were 21 years. The ages ranged from 22 months to 48 years.

In our analysis the cases were arbitrarily divided into those patients who did not receive aureomycin at all (Group A); those who received less than 2.0 grams of aureomycin in 24 hours (Group B); those who received 2.0 grams of aureomycin or more per day (Group C).

Of the 32 patients who received less than 2.0 grams of aureomycin per day (Group B), 24 recovered, 7 had residual paralysis, and 2 cases

of bulbar polio died. This group shows a recovery rate of 75%.

There were 16 patients who received 2.0 grams or more of aureomycin per day, (Group C), 14 of these patients recovered completely and 2 had residual paralysis which represents a recovery rate of 87.5%.

There were 4 cases, including 1 case of bulbar poliomyelitis, who received no aureomycin (Group A), and none of these recovered completely.

The 3 cases of bulbar polio in this study were children. One was a 6 year old girl who died 7 hours after admission to the hospital; she received no aureomycin. Another death from bulbar polio was that of a 10 year old boy, who was first admitted to another hospital where he was a patient for several days. After the diagnosis was definitely established, he was moved to St. Therese Hospital. At the time of admission he was cyanotic and dyspneic and had to be placed in a respirator. While being prepared for tracheotomy he died. Following his admission at St. Therese Hospital, he was given 500 mg. of aureomycin every 4 hours, a total of 2 grams having been administered by the time he expired. The third case of bulbar was that of a 5 year old boy whose history revealed headache, elevated temperature, and drowsiness for about 4 days. On the day of admission he was suddenly unable to swallow. There was a profuse amount of mucous present in his pharynx. His temperature at that time was 101.2°. Spinal fluid showed 281 cells with 66% lymphocytes, 34% neutrophiles and a positive globulin. He was immediately given 100 mgs. of aureomycin intravenously at 6 P.M. on the day of admission. This was followed by 500 mgs. rectally, after which he received 250 mgs. of aureomycin rectally every 4 hours. Forty-eight hours later his temperature was normal. He was alert, there was no mucous in the throat, and he was able to swallow. This boy made an uneventful recovery.

*Analysis of Duration of Temperature.*—The group of cases (4) who did not receive aureomycin is too small for statistical analysis. In Hoyne's[1] review of 225 cases of poliomyelitis, the average duration of fever for 187 of his patients was 4.8 days, which compares with the duration of fever in our Group B (those receiving less than 2 grams of aureomycin in 24 hours) of 4.4 days. Our Group C (those receiving 2 grams or more per day) had a temperature duration of 2.3 days. Statistical comparison of the difference of duration of fever between Groups B and C gives the following data. The mean duration of temperature in Group B was 4.4 and in Group C 2.3 temperature days. The standard deviation is 2.85 for Group B and 1.59 for Group C. The standard error of the mean equals .55 for Group B and .46 for Group C. The standard error of the difference between B and C equals .72. It gives a critical ratio of 2.94 which is interpreted to signify that there are 998 chances out of a thousand that the difference in duration of temperature is not due to a sampling error, and that there is a true difference between the two groups. This difference clearly reflects the result of adequate dosage of aureomycin. Herrell[2] recommends that an adult should receive 750 mgs. every 6 hours; for children he recommends 500 mgs. every 6 hours; for very young children and infants 250 mgs. every 6 hours.

*Analysis of the Recovery Rates.*—In Hoyne's series there was a mortality rate of 4%. The mortality in our series was 3.8%. There were two deaths, both from bulbar polio. One of these never received aureomycin, and the other received the drug when he was almost in a terminal condition.

*Recovery Rate of All Cases*—(Recovery being defined as return of function by the time the patient left the hospital)

Group A (4 cases receiving no aureomycin), none recovered, all being discharged from the hospital with paralysis.

Group B (32 cases receiving less than 2.0 grams of aureomycin), 75% had recovered by the time they left the hospital.

Group C (16 cases receiving 2.0 grams or more of aureomycin per day), 87.5% had recovered completely by the time they left the hospital.

Group A is too small to be considered in statistical analysis. The difference between Groups B and C is not statistically significant, the critical ratio being only 1.11% which means there are only 86 chances out of a hundred that the difference is truly existent and not due to a sampling error.

*Recovery Rate of Paralytic Cases Only.*—We have in our series in Group A, four cases with paralysis, none of whom recovered. This would give a recovery rate of 0%; but again Group A is too small to be considered in further statistical

analysis. Group B with 10 paralytic cases gives a recovery rate of 20%, and Group C with 8 paralytic cases gives a recovery rate of 75%. Comparing Groups B and C, the standard error of the difference is 21% which gives a critical ratio of 2.6. This is interpreted as meaning that there are 995 chances out of a thousand that the difference between the two recovery rates is truly significant.

*Comments.*—The question naturally arises whether or not all of the cases in this series were actually poliomyelitis. Fox and Wallace[3], discussing an outbreak of poliomyelitis occurring in the late summer and fall of 1947 in the Milwaukee area, had not a single case which they could classify as a paralytic out of a total of 87 cases. The symptoms presented by their cases fulfilled the criteria necessary for the diagnosis of polio with regard to histories, physical examinations, and spinal fluid findings. or unusual virus strain or the possibility of entirely unrelated encephalomyelitis. Curnen, They postulated the possibility of an attenuated Shaw and Melnick[4], who performed various studies on 13 of 157 patients diagnosed as poliomyelitis, discovered a new virus in 10 of these cases. In 10 other cases with definite paralysis they were unable to isolate this new virus. They carefully analyzed the clinical and laboratory features in all their cases and found a marked similarity between a true polio and the disease caused by the new virus which they designate as "C" virus. Since facilities for virus studies were not available to us, the new disease similar to poliomyeltis can not be ruled out in all cases, but there is no question that the paralytic cases were true polio.

*Conclusion.*—This series of 52 cases, diagnosed as poliomyelitis and treated with variable dosage of aureomycin, reveals information that is of more than coincidental significance. The effect of adequate dosage of aureomycin on the duration of fever in poliomyelitis was statistically shown. There are 995 chances out of a thousand that the recovery rate in paralytic cases was improved by dosage of more than 2.0 grams of of aureomycin per day.

## SUMMARY

Analysis of 52 cases of poliomyelitis is presented. Four of the cases did not receive aureomycin; 32 cases received less than 2.0 grams per day; and 16 cases received 2.0 grams or more of aureomycin per day. There was a statistically** significant difference in the recovery rate of paralytic cases and in the duration of temperature elevation between those who received adequate dosage of aureomycin and those who did not. With the dosage of 2.0 grams of aureomycin or more the duration of fever was about one-half as long as in those who received less than 2.0 grams or no aureomycin at all. We feel that aureomycin should be given further clinical trial in a larger series of cases, so that its clinical effectiveness in this disease can be further evaluated.

**We wish to express our gratitude to Mrs. Jane Weis for her statistical analysis in these cases.

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# Chemotherapy of Cancer

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*Dr. Taylor*: "Chemotherapy" is not the best term for the description of the effect of various drugs which have been used for palliative treatment of malignancies. It is true that our studies include a number of chemicals but most of our findings are based on the use of androgenic and estrogenic steroids. Consequently, this presentation is divided into a report on such drugs as colchicine, mustard nitrogen, the folic acid antagonists on one hand, a report on the effects of testosterone, stilbesterol and finally ACTH and cortisone on the other.

Of chemicals, colchicine alone or in combination with x-ray therapy has been tried because it has been known to inhibit mitoses. It is very toxic and of little clinical benefit. In fact, it might be mentioned here as a general rule that most drugs given in a sufficient dose to permit lysis of tumor tissue will also cause lysis of normal cells. Nitrogen mustards have been used with satisfactory though temporary results in Hodgkin's Disease. The improvement lasted from four weeks to five months. The effect is about equivalent to x-ray therapy but nitrogen mustards appeared to be superior if the process is very diffuse. We have also seen some effect in rapidly spreading carcinoma of the breast and others have used mustards for metastatic carcinoma as well as in polycythemia vera. I do not believe that the nitrogen mustards appreciably alter the longevity of the patients.

We have not had experience with stilbamidine and urethane which have been used by other investigators including Dr. Limarzi at this institution for the treatment of a multiple myeloma and carcinoma.

We have used the folic acid conjugate, teropterin, in a large number of cases of advanced carcinoma but have now discarded it. It is reputed to increase the well being of the patient, improve his appetite and decrease the need for narcotics. We have found a significant correlation between these effects and the investigator's enthusiasm. In other words, we feel that the effects are non-specific. Eighty-five patients have received this drug under our care. The folic acid antagonists, aminopterin, methopterin, and amino-an-fol have been reported to be of marked temporary benefit in acute leukemias. I have observed some of Farber's patients and it is my impression that although blood and bone marrow are improved, the patient is clinically debilitated. I feel that one reason the survival of these patients is prolonged is because incidental infections are promptly treated with antibiotics. We have treated a series of patients suffering from advanced carcinoma no longer amenable to surgery or x-ray with aminopterin. Our first case, a carcinoma of the lung, showed gratifying clinical improvement. The pathological process continued unabated, however, and the patient was dead within three months. Our subsequent experiences have revealed severe toxic reactions which can follow administration of this drug with alarming rapidity. They include ulcerative stomatitis, vaginitis, proctitis, vesicular dermatitis resembling a second degree burn, bloody diarrhea, ulcerative colitis, aplastic anemia and paneytopenia. We have found that these complications may arise even after the use of the drug has been discontinued. There is no way of predicting which patients will develop these severe reactions. Our second and third cases treated with this medication both developed aplastic anemias. This re-emphasizes the point previously made that drugs of this type not only affect the carcinoma cell but also cells of the bone

marrow, liver, kidney, bowel and other mucous membranes.

We have also tested guanizola intravenously. This is a new compound, a guanine inhibitor. Although it is too early to draw definite conclusions, we have noted neither improvement nor marked toxicity.

Our most convincing results have been obtained by the extensive use of androgenic and estrogenic steroids. In some instances no conventional treatment could have produced comparable improvement. Following castration and/or administration of stilbesterol, we have seen palliation of carcinoma of the prostate with metastases for periods exceeding three years. We have treated 112 cases of advanced carcinoma of the breast. Of these, 45% had temporary regressions after the use of estrogen, and 30% after androgen. Recalcification of bone metastases occurred in 32% of cases treated with androgen; and 54% showed relief of pain even though x-rays revealed progression of metastatic lesions in some. Estrogen produced recalcification in approximately 25% of osseous lesions. In patients under fifty years of age, estrogen tended to augment rather than improve the malignant process. In patients more than fifty years of age, however, 60 to 65% were improved. One of our patients who had an ulcerative lesion of the breast and refused operation has been now under observation the past four years. She has had several remissions with intermittent estrogen therapy. Even using the criteria of age for the selection of therapy in individual cases, occasionally a case in the older age group is augmented rather than retarded during estrogen therapy. We have no way of predicting how an individual patient will react. In some cases after we no longer observe benefit from one of the steroids we have induced additional palliation with the other. We have also found that in some cases progesterone could be used with good results after the androgens were no longer effective.

We are screening the effect of ACTH and cortisone on various malignancies at the present time. We have had one case of mycosis fungoides which has shown remarkable improvement — alleviation of itching and clearing of the skin lesions — following ACTH therapy. Within a week of withdrawal the skin lesions again flared up. During the second course of ACTH therapy, this patient developed diabetic acidosis and hypokalemia. This patient has now, we believe, a permanent diabetes.

One of our patients who had an Ewing tumor developed signs of Cushing syndrome and marked nitrogen deficit. At the same time there was definite clinical improvement but no regression of the growth. We have treated several patients suffering from lymphomas who appeared to experience effective temporary relief; one patient with lymphatic leukemia showed regression of lymph nodes and spleen while one patient with subacute myeloid leukemia failed to respond. In three patients with carcinoma of the breast who had been treated with ACTH, the process seems, in fact, to have been accelerated by the hormone. We are very much concerned by the side effects in patients on whom either of these drugs were continued for more than three weeks. Practically all noted serious though reversible psychic changes.

In summary, we feel that some of the agents, particularly the androgen and estrogen steroids, have definite merit in the palliative treatment of advanced malignacies. We feel, however, that we are still a long way from the final goal, namely, to "cure cancer."

*Dr. Harry A. Waisman, Research Associate in Pediatrics*: It seems significant that of all the folic acid antagonists, only aminopterin and methopterin are of value in the acute leukemias of children. Some of the other antagonists seem to work in different types of malignancies. For example, amino-an-fol has caused regression of some neuro-blastomas. Our experience agrees with the general impression that these compounds are certainly not a cure but that they are definitely effective in promoting the well being and prolonging the lives of these children. ACTH has been shown ineffective in acute leukemias but does seem to be effective in chronic forms. Much of the laboratory work shows various compounds to work in mouse leukemias while clinical trials showed very little effect in the human.

*Dr. Robert M. Jones, Clinical Assistant Professor of Medicine*: Chronic lymphatic leukemia is known to have spontaneous remissions without therapy. So, one would wonder whether isolated reports of improvement following ACTH might not be merely coincidental.

*Dr. Taylor*: The one case we have seen showed a dramatic decrease in the size of the spleen, but as you say, we need additional evi-

dence before we can interpret our results correctly.

*Dr. Jones*: Do patients who respond to the administration of androgenic or estrogenic steroids with recalcification of bone develop anemia?

*Dr. Taylor*: No, as a matter of fact the bone marrow appears to be stimulated. We have had several patients treated with androgen who actually developed polycythemia. As one of my colleagues stated, they die looking healthy.

*Dr. Melvin M. Cherlack, Clinical Assistant in Medicine*: What is the relationship of the dose of androgens and estrogens to the remissions?

*Dr. Taylor*: Our usual dose of stilbesterol is 15 mgs. per day. In one case we have obtained a comparable effect using as little as 3 mgs. per day. As far as the androgens are concerned, 100 mgs. three-times weekly does not appear to be more masculinizing than 25 mgs. three times weekly. We have found that 400 mgs. of testosterone is no more effective than 100 mgs. and probably a more physiological dose will give just as good a result.

Another question is when to begin therapy. Some authors recommend the use of steroids immediately after surgery but whether or not this will prove superior will require about ten years more of evaluation. We do not like to start testosterone unless necessary because of the possible stimulation of libido and hirsutism.

*Dr. James A. Schoenberger, Graduate Fellow in Medicine*: You mentioned one instance in which permanent diabetes was produced. What were your doses of ACTH and how long was it given?

*Dr. Taylor*: You are referring to the patient with mycosis fungoides. Before therapy, a normal glucose test was demonstrated. She was given at least 100 mgs. of ACTH daily for two months; after this, a diabetic glucose tolerance test was present. After one month of rest the patient relapsed and the glucose tolerance returned to normal. A second and third course of ACTH one month each, separated by one month without treatment followed — with a daily dose of at least 100 mgs. ACTH. One month after cessation of all therapy, there was a high diabetic type glucose tolerance test with persistent glycosuria.

*Dr. James D. Majarakis, Instructor in Surgery*: Can you produce repeated remissions with ACTH after periods of withdrawal and relapse?

*Dr. Taylor*: In some cases, yes. For example the patient with mycosis fungoides had repeated remissions. We have had a patient with Hodgkin's Disease who responded three different times. On the other hand, I have heard of a case of acute leukemia at Memorial Hospital which responded to the first course of ACTH but was later given 600 mgs. daily with no response. It has been suggested that antibodies to ACTH develop but I do not know whether this would be an adequate explanation for such a failure. Using cortisone, we have found that in some cases we must increase the dose as the disease progresses.

*Dr. Marcia Gordon, Resident*: What types of mental changes have you seen following the use of ACTH?

*Dr. Taylor*: We have seen depressions, manic-depressive reactions, delusions of grandeur and hallucinations. In one case we have seen identical symptoms of psychosis reappear three different times with three successive courses of treatment.

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

# Cavernous Hemangioma of the Liver

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A hemangioma is a neoplasm composed essentially of blood channels (whose cavities contain blood). The blood channels of a true hemangioma grow independently and are not governed by the laws that govern the growth and distribution of such vessels. They form a distinct mass which is separated from the general circulation; although there is usually an ingoing artery and an outgoing vein, the mass does not form any anastomotic relations with the surrounding capillaries or blood vessels. Rebbert laid great stress upon this lack of communication between the capillaries of a hemangioma and those of the contiguous tissue, and proved his point by injections. He further maintained that such tumors grow from their own vascular substance and not through the widening and assimilation of adjacent vessels. In other words, he believed that they were partial neoplasms originating from embryonic disturbances through which a displaced segment comes to possess a limited power of aberrant growth.

Regardless of their origin, the new blood vessels which constitute the growth are formed by budding of atypical angioblasts, a specially differentiated fibroblast. Active proliferation follows in the other elements of the vascular wall, terminating in the formation of the outer and middle coats of the new vessels from connective tissue and muscular constituents of pre-existing vessels. According to Moore, a far more logical hypothesis is that hemangioma of the liver is an acquired lesion resulting from destruction and necrosis of all of the liver cells in a focal region.

Growth takes place by the extension of the vascular buds into their surroundings, the adjacent tissue becoming completely displaced or infiltrated by the constant new formation or dilatation of capillaries. Metastases have never been observed. Increase in size is alternately slow and rapid, sometimes interrupted by long intervals or permanently arrested at some stage of growth. The center of the larger hemangiomas being the site of phlebolith formation due to a diminished blood supply and stagnation, is gradually replaced by scar tissue.

The favorite site for such hemangioma is under the surface of the left lobe of the liver extending from the transverse fissure to the left.

Growth is very gradual and ill-defined. As it grows, it displaces the hepatic tissue without infiltrating it or causing degenerative changes in the contiguous liver cells.

Cavernous angiomata are also common in the skin, where they form most of the so-called birthmarks which are so frequently seen on the face. These are usually dark purple and are often covered with rough nodular skin (nevus vinosus). The more definitely simple forms through which blood runs fairly rapidly present themselves as flat or slightly elevated, bright red patches from which the blood may be squeezed out (nevus flammeus). Other examples of simple angiomata are found in the muscles where they reach a considerable size. They are also found in the tongue, on the nose and lips, but in these situations the tumor is likely to have more of the cavernous character.

In 20,029 autopsies performed in the Cook County Hospital from 1928 to 1944, cavernous hemangioma of the liver was found in 140. The majority of these tumors were small and symptomless throughout the life of the individual. In only one case was the hemangioma of such size that encroachment of the surrounding organs may have caused pressure symptoms. They were either single, multiple or disseminated, and the majority were of the cavernous type. They were observed more frequently in women than in men, the ratio being approximately six to one.

Hemangiomas of the liver are rarely observed in children and become progressively more frequent with increasing age.

Case Report: M. R., a woman aged 43, entered the hospital on March 3, 1947, stating that six months prior to admission she began to experience a bloating feeling in the epigastrium following the ingestion of food which was similar to a sense of crowding. The distress was not selective in character. It increased in severity until at the time of admission partaking of even a small amount of food would bring on this sensation, accompanied by a dragging, heavy feeling in the upper abdomen. There were no other symptoms and at no time were her activities curtailed because of this condition.

On physical examination, the heart, lungs and blood pressure were normal. There was some distention in the epigastrium and on palpation there was a firm, nodular mass, extending to the level of the umbilicus, laterally to both midclavicular lines, and moving with deep inspiration. No tenderness was present. Percussion was flat and auscultation was negative.

The clinical laboratory reports were as follows: Blood examination showed normal erythrocyte and leukocyte counts, hemoglobin 80 per cent; blood protein level 7.6 grams per 100 c.c.; icteric index 6 mgms.; serum amylase and lipase levels normal. Gastric analysis showed free hydrochloric acid 30, combined 22, total 52; no blood was present. X-ray examination revealed an extragastric mass which encroached upon the lesser curvature of the stomach, causing a pressure defect. Intragastric examination was negative and emptying time was normal. Liver function tests, including cholesterol flocculation, thymol turbidity, and prothrombin time were normal. The urine was normal and the intravenous pyelograms were negative.

A laparotomy was performed on March 11, 1947 under sodium pentothal induction and ethylene-ether anesthesia. A left rectus incision was made extending from the level of the xiphoid process to the level of the umbilicus and the peritoneum opened. There was revealed a mass covered by thinned gastro-hepatic omentum. On incising the omentum there was a growth about 14 x 16 cm. in size, attached by a broad base to the under surface of the left lobe of the liver. The surface presented a soft purplish nodular appearance, dangerously thin in spots, soft and spongy in consistency, easily compressible in its periphery, while its center was firm, fibrous, shiny and whitish in appearance, giving a crateriform effect. The remainder of the liver, the spleen and other abdominal organs were essentially negative.

A portion of the tumor mass which was pedunculated was excised for microscopic study which revealed dilated, cystic, thick and thin walled vessels which contained red blood cells. The lining endothelial cells were large and pale and had elongated nuclei. The adjacent liver parenchyma was compressed and elsewhere the liver cells were pale, swollen, granular and vacuolated. The diagnosis was a cavernous hemangioma of the liver.

The patient made an uneventful recovery from the operation. Two months later she was given deep radiation therapy which was followed by a considerable reduction in the size of the

epigastric tumor. At the present time, three years after operation, the patient feels well and recent x-ray studies show that the pressure defect on the lesser curvature of the stomach is receding.

## COMMENT

The treatment of hemangioma is either by surgery, radiation therapy or a combination of the two. Surgical procedures are simplified if the growth has a pedicle (Morris, Peck, Morton, Shumacker). Serious complications, such as fatal hemorrhages, have occurred due to rupture prior to or at laparotomy. The excision must be made wide of the growth as hemorrhage, even a needle prick, may be uncontrollable. Tucker states that in the light of the newer surgical methods, particularly electrosurgery, surgeons could be bolder in attacking hepatic tumors. In the field of radiation therapy, Ray described his successful result in an inoperable case. A course of roentgen therapy was instituted, alternating anterior and posterior fields, with average dosage of 300 to 370 roentgen units. Over a period of four months, 5,772 r.u. were administered, and the series repeated to 4,602 r.u. after an interval of four months.

Pozzi states that the total number of reported cases of angioma operated on up to 1933 was 36. Basing his figure on the results in these 36 cases, he estimates the operative mortality at about 20 per cent.

The operation is simple when the vascular connections with the liver are well defined and can be controlled by clamping and chain or overlapping ligatures. The non-pedunculated or sessile growths which are embedded and incorporated in the liver substance are practically inoperable. The whole left lobe from the level of the suspensory ligament has been repeatedly and successfully excised when a distinct sulcus or line of demarcation separated the neoplasm from the liver proper. (Cases reported by Cabanes, Celleoni, Peck). On the other hand, a simple exploratory laparotomy may cause death by the tearing of adhesions and the rupture of the thin pellicle covering of a large cavernoma. The same thing may happen from the strain of vomiting and increase in the intratumoral tension or the steady hemorrhage from an exploratory puncture. Such cases were reported by Cheora, Freund, Mantle, Jones, Borst, Pagenstecher and Pozzi (Quoted by Pozzi).

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# CASE REPORTS



# Dermatitis Medicamentosa Caused by Mesantoin

**Jerome M. Greenhouse, M.D. and Eric Lehr, M.D.**
**East St. Louis**

Mesantoin is a drug that has been shown to be of definite value in the control of grand mal type of epilepsy by many investigators. Among the side effects reported have been skin rashes[1] of a generalized and morbilliform type accompanied by intense pruritus. This side effect occurred in 3 patients (4½%) of a group of 67 epileptic patients treated with Mesantoin in a dose of 0.3 to 0.4 Gm. (4½ to 6 grains) daily; the rash disappeared in about ten days after discontinuing the drug. One patient ran a temperature of 103° F for two days. Two of the three patients were subsequently given the drug again without toxic effects. The drug was again immediately stopped in the third patient when pruritus was reexperienced. Another investigator[2] treated a total of 104 patients with Mesantoin and found 7% experienced a skin reaction. Three patients who developed a rash on dilantin sodium, precluding continued use of such, succeeded in taking Mesantoin. Lenox[3] reported 14% of 35 cases treated with Mesantoin developed a generalized measles-like rash. Ruskin[4] was the first to report a case of dermatitis medicamentosa due to Mesantoin in which the mucosal surfaces of all the body orifices were involved. This occurred in a 10 year old white female after 12 days of Mesantoin in the dosage of 0.3 Gm. daily and was accompanied by a leukopenia with a relative neutropenia and a terminal anemia. This case terminated fatally with an exfoliative dermatitis, the patient having lost the superficial layer of the skin of two-thirds of the body. Ruskin also stated that in a series of cases treated with Mesantoin, 3.8% developed a scarlatinform rash when they received 0.1 Gm. daily. This rash disappeared when treatment with the drug was discontinued, and did not reappear when the patient was again receiving the drug. By starting, the second time, with a smaller dosage and raising the dosage slowly, it was eventually possible for the patient to receive 0.3 Gm. daily.

We wish to present the second case reported



**Figure 1. Appearance of patient while taking Mesantoin.**



**Figure 2. Patient two weeks after Mesantoin was discontinued.**

of dematitis medicamentosa due to Mesantoin in which the mucous membranes of all the bodily orifices were involved. In contrast to Ruskin's case, however, our case survived.

Mrs. H. E., 50 yr. old female, with history of periodic grand mal convulsions for many years, had been controlled with dilantin sodium until the summer of 1948, when she was switched to Mesantoin (0.3 Gm. B.I.D.). Within two weeks her skin began to itch and she broke out in small blisters. Mesantoin was stopped and dilantin was substituted and her eruption subsided. On 8/11/48 her left breast was removed for adenocarcinoma. Post operatively, 1900 roentgen units were given to each of small supraclavicular nodes, breast and axillary areas, following which there was a mild expected radiation reaction which soon cleared. While convalescing at home, the patient was put back on Mesantoin and within one week a burning and itching rash reappeared with small blisters on her skin. The eruption began on the operative site as a red rash which gradually became generalized and appeared in the mouth, eyes, vagina and anus, necessitating rehospitalization.

Physical examination on 9/19/48 revealed an acutely ill patient with a generalized florid eruption of multiform character. There was an erythematous almost solid sheet of dermatitis on the upper half of the chest with its greatest intensity around the operative incision on the left anterior chest. (Figure 1) There was a moderate purulent discharge from the upper part of the operative wound. Pinhead to half dollar size erythematous oval macules were scattered over the rest of the body with both clear and hemorrhagic vesicles and bullae in the center of many of the macules. The lips were fissured, bleeding and covered with blebs, erosions and exudate. The tongue was swollen, bright red and fissured. The entire oral mucosa was angry appearing and denuded with shreds of eroded epithelium hanging loosely and easily wiped away with a sterile swab. The eyelids were adherent and a purulent discharge escaped from the lid margins due to a severe conjuntivitus. The vaginal and anal mucosae presented a similar picture to that of the mouth. The rest of the physical examination was essentially normal.

There was pain and burning in the mouth, vagina and anus, and the patient was unable to take either liquids or solids by mouth. The temperature varied from 101° to 105° F. until two days after stopping Mesantoin, following which the temperature gradually became normal, except for slight elevations from time to time until the date of discharge on 10/11/48. These slight elevations were probably due to absorption from the infected operative wound in the left axilla, which finally healed completely.

As indicated above, the patient gradually im-

proved after the Mesantoin was stopped. The skin and mucosal lesions subsided and gradually faded away. Within one week the patient was able to take fluids by mouth and in the second week of convalescence, solids were taken by mouth. At the time of discharge, she was entirely free of all skin and mucosal lesions. (Figure 2)

Laboratory Data: Blood count showed a moderate secondary anemia. The W.B.C. was 19,650 on 9/20/48, on 9/23/48 it was 3,000 and on 10/7/48, 3,900. The differential count was within normal limits at all times except on 9/25/48, when, with a total W.B.C. of 4,100, there were 25 eosinophiles and 15 lymphocytes. The urine was normal. The sedimentation rate was 34 mm. per hour on 9/24/48. The total proteins were 5.8 with albumen 3.4 and globulin 2.4. A differential done on one of the bullae showed the following: seg., 15; lymph, 39; mono., 37; eos, 6.

The systemic therapy consisted of penicillin for two weeks, 1 Gm. streptomycin daily for one week, intravenous glucose, one 500 cc blood transfusion and 100 mg. nicotinamide I.M. q.i.d. Locally, mild anti pruritic lotions and colloidal baths were used on the skin. Sodium perborate mouth wash and iodized phenol swabs were used in the mouth, while 2% aqueous solution of gentian violet was applied to the anal and vaginal mucosae. Boric acid solution was used to lavage the eyes daily. After the patient was able to swallow liquids, elixir sodium salicylate was given daily for one week. The operative incision was dressed with xeroform and boric acid ointments.

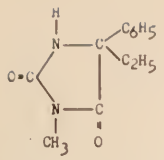
*Similar Reactions From Other Anti-Convulsive Drugs.*—Other drugs used in the treatment of epilepsy give rise to bullous eruptions of the type herein described. Among these are Tridione, and recently a case was reported resulting in blindness in a 6½ yr. old boy[5]. Lenox[3] noted that of the side effects in 230 patients treated with Tridione, skin reactions were encountered more often than with phenobarbital or dilantin sodium. There was either a generalized measles-like rash or minute hard papules in the skin of the face or forehead. One patient had erythema multiforme with leukopenia and fever. In all but a few instances, tolerance to the drug could be established by first withdrawing it and then giving small and slowly increased amounts. DeJong[6] reported a skin eruption on one patient (1.6%) in a series of 60 patients treated with Tridione.

A case of ectodermosis erosiva pluriorificialis in an 11 yr. old white girl was reported by Ellis[7] following the ingestion of 0.1 Gm. of dilantin sodium twice daily for three weeks. Several other cases of dermatitis medicamentosa have been reported in literature since the introduction of dilantin sodium.

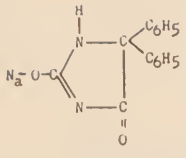
Dermatitis medicamentosa with mucosal involvement due to barbiturates showing an erythema multiforme-like pattern on the skin is reported by Montgomery.[10] Millard[8] reports a fatal case of erythema multiforme bullosum with involvement of the mucous membrane orifices. Moss and Long[9] reported two cases of severe bullous lesions of the skin and mucous membranes due to phenobarbital, and pointed out the close resemblance to ectodermosis erosiva pluriorificialis. They express the belief that in some cases reported under this diagnosis, phenobarbital may have been the causative factor.

Nirvinol, used in the treatment of chorea, is a highly toxic drug which may cause a macular rash, fever, eosinophilia, stupor and granulocytopenia.

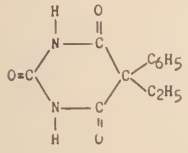
*Chemical Similarities.*—Comparison of the structural formulas of the most commonly used anti-convulsants will show their close chemical similarity and relationship. (Figure 3). Dilantin sodium and Mesantoin are both hydantoin derivatives. They may be considered as derivatives of a cyclic condensation product of urea and acetic acid, whereas phenobarbital is a derivative of the cyclic condensation product of urea and malonic acid. It is noted that one phenyl group of the dilantin sodium is replaced by an ethyl group in Mesantoin; in addition, the double bond nitrogen atom in dilantin sodium is replaced by a methyl group in Mesantoin. Furthermore, dilantin sodium is used in the form of the sodium compound, whereas Mesantoin is sodium-free and has the chemical characteristics of a weak acid. Tridione is not a hydantoin derivative,[11] but is related in structure to Mesantoin in that an oxygen atom has been substituted for the No. 1 nitrogen of Mesantoin, and two phenol groups have been substituted for the ethyl and phenyl groups on C No. 5. Nirvanol differs from phenobarbital by having one CO group less and differs from Mesantoin



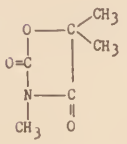
Mesantoin ( 3-methyl-5, 5-phenylethyl-hydantoin)



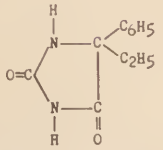
Dilantin sodium (Diphenylhydantoin sodium)



Phenobarbital (phenylethyl barbituric acid)



Tridione (3,5,5-trimethyloxazolidine-2, 4 dione)



Nirvanol (phenyethyl hydantoin)

**Figure 3. Structural chemical formulae of commonly used anti-convulsant drugs.**

which has a $CH_3$ group in place of an H atom attached to one of the N atoms. Mesantoin seems to be less toxic, but is a hydantoinate, and, in persons sensitive to this chemical group, abnormal reactions should be expected.

## DISCUSSION

The case reported fulfills most of the criteria for the diagnosis of dermatitis medicamentosa. There was a history of a skin eruption following ingestion of Mesantoin which disappeared upon discontinuance of the drug. Several weeks later, when Mesantoin was readministered, a similar eruption appeared which also resolved upon stopping the drug (therapeutic test).

Localzo,[12] commenting on Ruskin's case, brought out the fact that the patient reported on had already shown dermal sensitivity to a variety of drugs, including dilantin, phenobarb and sulfonamides. He also states that small dosages can initiate a rash in skin-sensitive patients. The severity and duration of the rash are dependent to a large extent, on the degree of the patient's sensitivity and are not necessarily related to the amount of drug ingested.

To our knowledge, this is the first non-fatal case of dermatitis medicamentosa with pluriorificialis involvement. Noteworthy, also, is the fact that the eruption appeared originally over the operative wound site (Koebner phenomenum).

The erythema multiforme bullosum type of dermatitis medicamentosa with pluriorificialis involvement should be differentiated from ectodermosis erosiva pluriorificialis and the Stevens-Johnson syndrome. In the original two cases presented by Stevens-Johnson[13] there were no subjective symptoms of pain or itching at any time. Also, a skin eruption from drug ingestion was ruled out by careful inquiry which showed that no drugs whatever had been administered in either case. Lever[14] points out that severe erythema multiforme with involvement of mucous membranes must be differentiated from eruptions due to drugs, while Keil[15] states that erythema multiforme exsudativium (Hebra) should be differentiated from drug eruptions. He also states that ectodermosis erosiva pluriorificialis and Stevens-Johnson syndrome are merely variants of erythema multiforme exsudativum. Andrews[16] states that ectodermosis erosiva pluriorificialis and Stevens-Johnson disease must be differentiated from drug eruptions. Perhaps pruritus and a history of a drug ingestion may aid in differentiation. Of course, the final criterion, as pointed out above, is a reappearance of the same eruption upon readministration of the drug.

## SUMMARY

A case of dermatitis medicamentosa due to Mesantoin involving the skin and mucous membranes of all the bodily openings is reported.

The chemical relationship of Mesantoin to related drugs causing similar rashes is pointed out.

The differentiation from Stevens-Johnson syndrome and ectodermosis erosiva pluriorificialis is stressed.

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## RESEARCH FELLOWSHIPS

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1951-June 30, 1952. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The stipend will be from $2,200 to $3,200.

Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than October 1, 1950. Announcement of awards will be made November, 1950.

## COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association, announces that its course in Postgraduate Gastroenterology will be given at the Hotel Statler in New York City on October 12, 13, 14, 1950.

The course, which will again be under the personal direction of Dr. Owen H. Wangensteen, Professor of Surgery, University of Minnesota Medical School, will cover the following subjects: Diseases of the Mouth; Diseases of the Esophagus; Peptic Ulcer Diseases of the Stomach; Diseases of the Pancreas; Cholecystic Disease; Psychosomatic Aspects of Gastrointestinal Disease; Diseases of the Liver; Diseases of the Colon and Rectum and other miscellaneous subjects including Pathology and Physiology, Radiology, Gastroscopy, etc.

For further information and enrollment write to the National Gastroenterological Association, Dept. GSJ, 1819 Broadway, New York 23, N. Y.

# HOUSE OF DELEGATES



## FIRST SESSION, MAY 23, 1950

The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Abraham Lincoln Hotel, Springfield on Tuesday, May 23, 1950.

The meeting was called to order at 3:25 P.M. by the President, Dr. Walter Stevenson, Quincy.

The first order of business was the roll call of the officers and members of the Council.

The next order of business was the report of the Credentials Committee.

DR. E. S. HAMILTON, Kankakee: The Credentials Committee has certified 5 officers, 17 members of the Council and 138 regularly elected delegates, making a total of 150 present. I move you that this constitute the official voting strength for this meeting. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE PRESIDENT: The next order of business is the approval of the Minutes of the annual meeting for 1949 as published in the July-August issues of the Illinois Medical Journal.

DR. W. E. KITTLER, Rochelle: If there are no objections or corrections, I move that the Minutes be accepted as published in the July-August, 1949 issues of the Illinois Medical Journal. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

THE PRESIDENT: The next order of business is the appointment of Reference Committees. The following Committees have been appointed:

*Committee on Attendance:* Drs. Albert Mickow, Chairman, George E. Kirby, Anders Weigen and James K. Rosson.

*Committee on Reports of Officers:* To receive and report on reports of: President, President-Elect, Secretary-Treasurer: Drs. Mather Pfeiffenberger, Chairman, Frank P. Hammond, Dale E. Scholz and Frank Fowler.

*Committee on Reports of Councilors:* To receive and report on: reports of: Chairman of the Council, Reports of Eleven Councilor Districts and Councilors-at-large: Drs. R. C. Oldfield, Chairman, C. Ellsworth Black, Fred H. Muller and J. J. Grandone.

*Committee on Reports of Standing Committees:* To receive and report on reports of: Committee on Medical Service and Public Relations, Committee on Medical Testimony, Committee on Medical Education and Hospitals, Medico-Legal Committee, Medical Benevolence Committee and Committee on Archives: Drs. Charles H. Phifer, Chairman, B. E. Montgomery, Frank F. Maple and Frank Deneen.

*Committee "A" on Reports of Council Committees:* To receive and report on reports of: Educational Committee, Scientific Service Committee, Postgraduate Committee, Fifty Year Club Committee, Medical Economics Committee and Committee on Physical Therapy: Drs. Frank M. Hagens, Chairman, R. Greening, D. H. Trumpe and Elmer V. McCarthy.

*Committee "B" on Reports of Council Committees:* To receive and report on reports of: Advisory Committee, Illinois Public Aid Commission, Constitution and By-Laws Committee, Advisory Committee, American Academy of Pediatrics, Committee on Prepaid Medical and Surgical Care and Committee on Mental Hygiene: Drs. G. Henry Mundt, Chairman, Charles Allison, S. M. Goldberger and David B. Freeman.

*Committee "C" on Reports of Council Committees:* To receive and report on reports of: Committee on Cancer Control, Committee on Tuberculosis Control, Committee on Venereal Disease Control, Advisory Committee, Veterans Administration and Committee on Military Affairs and Emergency Medical Service: Drs. J. H. Edgcomb, Chairman, Casper Epsteen, Peter B. Rumore and G. E. Johnson.

*Committee "D" on Reports of Council Committees:* To receive and report on reports of: Committee on Rural Medical Service, Crippled Children's Clinic Committee, Committee on Industrial Health, Maternal Welfare Committee and Ethical Relations Committee: Drs. James H. Hutton, Chairman, James C. Ellis, Robert Mustell and T. G. Knappenberger.

*Committee to Receive and Report on:* The reports of: The Editors, Illinois Medical Journal, Committee on Scientific Work, President, Woman's Auxiliary, Advisory Committee, Woman's Auxiliary and Advisory Committee, United Mine Workers: Drs. Ralph McReynolds, Chairman, Karl L. Vehe, C. Paul White and Harry J. Dooley.

*Committee on Miscellaneous Business:* To receive and report on the reports of: Committee on Nutrition, Committee on Medical History, Advisory Committee — State Commission on the Chronically Ill, Illinois Delegates to the A.M.A. and any other matters referred by the President: Drs. M. M. Hoeltgen, Chairman, V. B. Adams, A. C. Taylor and Walter Baer.

*Committee on Resolutions:* To receive and report on resolutions introduced at the First Meeting of the House of Delegates: Drs. P. R. Blodgett, Chairman, W. W. Fullerton, Harold W. Miller and Bernard Klein.

THE PRESIDENT: The next order of business is the presentation of annual reports. These have been published in the Handbook but they can be supplemented if so desired. The Chair will rule about supplementary reports. Some of them may be very long; if they are very short they will not take much of your valuable time. I would rule that the Chairman who is making the report or any member of the Committee who has a supplementary report will turn it over to the Reference Committee without reading.

DR. OSCAR HAWKINSON, Oak Park: I move that we accede to your wishes. (Motion seconded by Dr. E. E. Davis, Avon and carried).

THE PRESIDENT: There is one supplementary report which we will hear, Dr. Stanley Olson, Dean of the University of Illinois, appearing for Andrew C. Ivy.

## 1950 REPORTS OF OFFICERS AND COUNCILORS

### REPORT OF THE PRESIDENT

This is a report of progress. The American medical profession, which, as you know, has been thrust into a position of leadership in this 20th Century fight to keep America free, has made and continues to make definite progress in the effort. The Illinois State Medical Society, in all its various undertakings, is for the most part carrying its full share of the burden.

Summarizing briefly the most important phase of our program, I might point to three major facts:

One, the indications of the moment are that a full scale compulsory sickness insurance program has been shunted to the sidetrack for the time being, as a result of our efforts and those of our allies. Nevertheless, we must continue on the alert. In the minds of all the do-gooders in Washington, socialized medicine still is the major program, but now (two) they are seeking a sort of piecemeal approach to Socialism that keeps us fighting one minor step after another. Three, the imminence of the Congressional elections gives us a unique opportunity to abandon our hitherto defensive role and go on the offensive to help elect men who will resist all forms of State Socialism, including socialized medicine, whether by way of S. 1679 or the various "fringe-bills" in the last year.

THE PRESIDENCY—Your president has been exceedingly busy in the last year traveling to various parts of the state addressing medical societies, non-medical organizations, and non-medical audiences. I have obtained a great number of anti-Socialism resolutions and delivered some sixty public addresses. It has been a great pleasure to do this because it is so easy to prove to people that medical care in this country is just what they need and what they still want. Many non-medical people are horrified when they learn what socialized medicine will mean to medical care in this country and how far along towards a total socialistic state we will be if a socialized medical program on a national level should be put into effect.

I have attended every meeting of the Council of the Society. I have attended a great many of the various committee meetings and altogether it has been a very happy year, in which I have tried to contribute in my feeble way, of energy and time toward making the profession in this state a bigger and better one. We are doing a good job of medical care in this state and I have heard no complaints anywhere in Illinois that the medical profession is not fulfilling its duty to the people. It has not been my privilege to attend all of the postgraduate conferences, but I have attended a number of them and I am on the program of several more before the year is out.

THE COUNCIL—Having attended many Council meetings, including my service as Councilor of the Sixth District, I am now in a position to invite your attention to the ever increasing economic business of the society, which necessarily must be composed in the interval between the annual deliberations of the House of Delegates. In years past, the regular business of that body, begun during the morning of Sunday designated for the meeting, used to be completed during the morning session; now the meetings last into mid-afternoon. In addition, many Council members belong to special committees which meet on the afternoon and evening before the regular session. One committee even meets as early as 7:00 a. m. on Sunday. The result is that it usually now takes a day and a half to two days to handle the society's affairs.

The Council as a whole and its individual members deserve your appreciation. The Chairman of the Council, Dr. Oscar Hawkinson, has made a fine presiding officer during the past year and I want to recognize and officially commend his energy, his outstanding fairness and his many courtesies to the Council.

THE SECRETARY-TREASURER—Dr. Harold M. Camp, in whom you have bestowed your confidence for 26 years now, is an almost indispensable officer of

your Society. Under his direction, the completely able and efficient headquarters corps functions faultlessly. The business of this office has multiplied by leaps and bounds and nothing but praise can be said as to the efficiency, energy and the earnest endeavors of Dr. Camp.

THE EDITOR, THE EDITORIAL BOARD, THE JOURNAL COMMITTEE—The *Illinois Medical Journal* is certainly one of the most outstanding scientific publications of its type. The editorials are well written and timely. The scientific articles are well selected and of great educational value and other features of the *Journal* are all that could be desired. For all this, thanks are due to the editor, Dr. Camp, to his able new associate, Dr. Theodore R. Van Dellen.

Much praise should likewise be given to the Editorial Board, whose chairman is Dr. James H. Hutton. That Board, which goes over the various articles submitted for publication has shown unfailingly excellent judgment in the selection of the articles. The Journal Committee, under the able direction of Dr. Harry M. Hedge, has done an excellent job so far as the business side of the *Journal* is concerned and Mr. L. E. Malley has proved to be an able business manager. The process of rehabilitating and modernizing the *Journal* typographically has been carried on skillfully and painlessly and the publication as a result is one of which we can all be proud. The *Journal* deserves our unstinted support and those responsible for its excellence our heartfelt thanks.

THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH—It is most gratifying to know that Dr. Roland Cross is still the head of this important department of our state government and I am sure we owe Governor Adlai E. Stevenson, who saw the wisdom of continuing Dr. Cross as Director, an expression of commendation. The Department is a distinct part of the activities of the Illinois State Medical Society and I hereby personally acknowledge the fine cooperative spirit of its entire personnel under Dr. Cross in our efforts to improve the health of the people of Illinois. I will dispense with further discussion of Dr. Cross' excellent work, for I know you will be deeply interested in his own reports, particularly as they concern the establishment of county public health units and the building of new hospitals. In all his many activities Dr. Cross has fought a good fight for the public good and always in such a way as to earn our sincere praise.

PUBLIC RELATIONS—Events of the last decade have finally awakened the medical profession to the fact that for a century we have neglected to keep the public abreast of our unselfish interest in and efforts for all that pertains to the good health of the people of the State of Illinois. Thanks to the wisdom of Dr. James H. Hutton of Chicago and the Council over the last quarter-century, we now have one of the best public relations departments in the nation charged with the duty of overcoming that ancient fault. The report of the Committee on Medical Service and Public Relations cannot fail to impress upon you the vast amount of work being done for us. In no small way the service it contributes has made us all conscious of our responsibilities and helped us to dispel many of the misunderstandings prevalent in the public mind regarding our aims and endeavors.

Following the resignation of Dr. Hutton as chairman of this committee, we were able to induce Dr. Percy E. Hopkins of Chicago to take over the post. Results speak for themselves. Dr. Hopkins has done magnificent work, and has earned great commendation for his devotion to duty.

In his efforts he has the aid of an able executive in the person of Mr. James C. Leary, who is the director of public relations for the society. Mr. Leary's intelligence, keen mind and unflagging diligence have been outstanding, and his work has set a pattern in many respects for programs of other state medical societies. This one activity, public relations, has been an outstanding achievement of this Society and, I am sure, has done a great deal of good not only for the profession but also for the public.

The society has also been served with energy and ability by its General Counsel, Mr. John W. Neal, whose difficult and delicate task it is to act as official observer and advisor for the society in medico-legal and medical legislative affairs.

The chairman and the committee, with which the president is affiliated ex officio, have cooperated with many other groups and they are deserving the highest enconiums from this society.

Before leaving this subject, I feel that it is my duty to point out to you the importance of the coming year in our fight to the death, both as patriotic citizens and as medical men, against Socialism in all its forms. With congressional elections to be held in November, it is essential that our campaign of public education be stepped up materially and it will probably be necessary to set aside additional funds for the use of the Committee on Medical Service and Public Relations to be expended at its discretion when, as and if needed in the many-front warfare in which they are shock troops. We are in the greatest battle of our lives, both for the good of our country and the preservation of our professional freedom. It is the most important activity of the society, and everything else could well be subordinated to it, if necessary, as is the case in many other state societies. No effort can be too great, individual or collective, and all our energy and resources must be made available on instant call for it. What will any medical society's reserve funds be worth if Socialism prevails? A single brief amendment to the tax laws could sweep them out of existence overnight—and undoubtedly would if a "rubber-stamp" Congress is elected. I submit this fundamental thought for the most serious consideration of the House of Delegates.

THE EDUCATIONAL COMMITTEE—The Educational Committee, under the able chairmanship of Dr. Charles P. Blair, goes on with its splendid program of health education started many years ago. Its report, I am sure, will prove most interesting to the House of Delegates. Miss Ann Fox, its secretary, has done well in the routine activities of the program and

in addition has aided in the development of a pioneer health education program on WGN-TV, a Chicago television station. The program has built up a high level interest in the limited area now served by television and I am certain its importance and influence will expand with the development of this new medium.

POSTGRADUATE AND SCIENTIFIC SERVICE COMMITTEES—It seems almost unnecessary to mention these committees. They, of course, will have a detailed report. As in years past ever since its inception, the work of these committees have shown by results their value to the Society. Each year sees an increase of postgraduate conferences. The fact that more and more areas demand these meetings speaks well for the good being accomplished. In addition to the postgraduate conferences, these committees stand ready at all times to aid any county society with their scientific programs. Dr. Robert Berghoff deserves credit for the splendid results accomplished by these activities.

RURAL MEDICAL CARE—The work of this committee, under the forceful guidance of Dr. Harlan English, has not only attracted the attention and admiration of the profession and people of this state, but is an examplar for other state societies. The committee is extremely active and has held many many meetings. In cooperation with the Illinois Agricultural Association, this committee has now filled each year our contemplated goal of four medical students each year. This praiseworthy program is outstanding and is doing much to offset the criticism of the profession regarding so-called failure to furnish medical care to the rural areas of this state. Much praise is due this committee and to Dr. English, its chairman.

MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE—The chairman of this committee, Dr. Earl H. Blair, is sincerely interested in the activity, and has made great personal sacrifices in his realization of the potential dangers arising from our international blundering and in his desire to serve his profession and the people of Illinois. I am sure that you will read his report with great interest. Dr. Blair has done a good job not only during the past year on this committee but he also served us for a number of years. He has earned our sincere gratitude.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS—This committee will of course have a report of its activities during the past year. However, I do want to state that the committee has been called on a number of times to investigate and to report with recommendations on matters properly referred to it. This committee has functioned well and has done a grand job. Their reports to the Council have been complete and informative thus enabling the Council to solve many problems intelligently and sufficiently. Much praise is due to Dr. Willard O. Thompson and his committee.

COMMITTEE ON MEDICAL BENEVOLENCE—At long last, this committee under the able guidance of Dr. Oscar Hawkinson is no longer handicapped by the lack of funds. This work is carried on quietly and efficiently and I can assure you that every application for benefits from this fund is given fair and impartial consideration. I commend this meritorious committee.

COMMITTEE ON MEDICAL ECONOMICS—This committee is rendering increasingly better service to the Society. The pages allotted to the committee in the *Journal* are being used every month and the articles are well worth the attention of the general profession. Thanks to the committee and to the Chairman, Dr. Chauncey Maher.

ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION—Dr. Everett Coleman still continues as Chairman of this important committee. The committee has excellent cooperative activity with the Executives of the Commission and has its full confidence. Medical problems are left pretty much to the decision of this Advisory committee and I am glad to commend the committee for its excellent and painstaking work.

THE WOMAN'S AUXILIARY—The Woman's Auxiliary has carried out its functions with great earnestness and devotion. I think too few of us realize how important the auxiliary is to the society. The women associated with this very important department of our society can do much to improve our public relations and they have never yet failed to respond energetically to the often severe demands made on them. The Cook and Sangamon County auxiliaries have been especially active in cooperation with our public relations program. They are also interested in doing all that they can to furnish material to complete the medical history of Illinois. The auxiliary can continue with our encouragement to be a great asset to our society. My praise to them and sincere thanks.

SOCIETY FINANCES—The increasing amount of business which our society is called on to perform has been a severe drain on our resources. The financial report will show that we are not quite as well off at the end of this year as we were last year. But there are good reasons for it. We had to dip into our reserves to accomplish our purposes. That is why surplus money is stored up. If ever there was a time in the history of medicine when an emergency presented itself, it is now. I know that the finance committee has done its earnest best to keep expenses down, but there are some expenses which are unavoidable.

The finances of this society are looked after by the very able and conscientious Dr. Edwin S. Hamilton, Dr. Charles P. Blair, and Dr. Arkell M. Vaughn. They devote much time to consideration of bills rendered and I want to thank them personally and in the name of the society for the good job they have done.

GRIEVANCE COMMITTEE—Those of you who have followed our medical magazines, particularly *The Journal of The American Medical Association* are cognizant, I am sure, of the advice that every state society and every county medical society should have a grievance committee to receive complaints from the public regarding medical service and to investigate and act on them. This was adopted in one of the larger downstate societies and others are in the process of establishing such groups. I would recommend that the

House authorize such a state committee and repeat the suggestion formally at this meeting to all our component societies. Such committees can serve well to back up our public relations campaign and to eliminate grievances on which antagonists are often based—especially overcharging.

In closing, I congratulate the society on the scientific work which has been accomplished. And I must call your attention to the devotion to duty and to public welfare of the many committee chairmen and members through whom the multifarious activities of the society are carried out. Without their freely-given volunteer help, your officers and your society would be powerless. I have touched on only a few of the more generally known groups, but there are dozens more who have earned our sincere and heartfelt thanks and commendations.

I particularly wish to congratulate all the members of the profession in this society for the splendid cooperative spirit that they have manifested in our fight against socialized medicine. We must not fail to continue these efforts in the future. Now is the time to follow up the victories which we have already obtained. Let us once and for all put to sleep forever the agitation which goes on at Washington, by mobilizing public sentiment to send to Congress men who will block forever the minority groups seeking to socialize the medical activities of this country. In retiring from this office I am sure that you have selected an excellent President for next year. I know that he will be surrounded by a splendid corp of assistants and that the administration of Dr. Harry M. Hedge will enjoy the same cooperation that so many of you have rendered to me. I want to thank you very much for the great honor you have given to me by letting me serve you and our great profession as your President. I will always render whatever aid I can to the profession of this great state.

Respectfully submitted, WALTER STEVENSON, M. D., *President.*

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### REPORT OF THE PRESIDENT-ELECT

The work of the past year has been fairly heavy but, as I am told, only an introduction to what is in store for me in the year to come.

Since the first of January, 1950, I have been out of the city on seven appointments and have filled twenty-one speaking engagements. Some of these have been on scientific subjects and some on our stand in the opposition to socialized medicine. I feel that there has been a definite progress made toward giving the people at the grass roots level a sound basis for their opposition to socialized medicine and eventually if that comes then the socialized state.

It has been a very enjoyable year in association with the various county and district organizations and with the various officers in the county, state and national societies. I greatly appreciate the honor that the Society has given me during the past year and its hearty reception wherever I have appeared.

I trust that all problems which may arise during the next twelve months may be satisfactorily adjudicated by the help of conferences, committees, and the advice of individual members.

Respectfully submitted, HARRY M. HEDGE, M. D., *President-Elect.*

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### REPORT OF THE SECRETARY-TREASURER

At the midcentury meeting of the Illinois State Medical Society we are confronted with many problems a far cry from those faced in 1900. At that time reports at the annual meeting were being presented by special committees on such subjects as pneumonia, tuberculosis, typhoid fever and many other diseases. The routine reports of these committees before the House of Delegates until the year 1899, were published in book form and sold to members at the actual cost of publication.

Today we face continuous efforts to increase bureaucratic control over many activities of the American people and to decrease incentives for a continued free and competitive economy. This nation was founded on the principles of free enterprise which applies not only to the practice of medicine but also to all endeavors which have made this a truly great country.

THE SUBJECT OF DUES.—Two years ago the American Medical Association started its National Education Campaign. The first year it was financed largely by voluntary donations on the part of the membership in the form of a special assessment. This received much comment in the press, over the air and from the rostrum. Approximately 85 per cent of the members of this Society paid the assessment. This office still receives an occasional check for the 1949 special assessment from physicians who are paying their state society and A. M. A. dues.

At the Interim Session of the A. M. A. in Washington last December, the House of Delegates, for the first time in 102 years, unanimously voted to assess annual dues against members. These dues are to be collected at either the county or state level according to the policies of the individual state or territorial medical society. The Board of Trustees of the A. M. A. has devoted much time to the development of plans governing this activity and to considering seriously the problems concerning members of state societies who are exempt from the payment of dues at the county and state levels.

Official reports from the Board have been published in the Journal of the A. M. A., in our Illinois Medical Journal, and sent out from this office to all component societies. Articles have gone out from this office in the Secretary's Newsletter. The April 1 issue of the JAMA carried an official statement from the Board of Trustees in the form of questions and answers, giving factual information on the subject. It is shown that all members of the A. M. A. shall pay dues with the exception of those in three specific categories:

1. Members for whom the payment of dues constitutes a financial hardship as determined by their local medical societies.

2. Members in actual hospital training for not more than five years after graduation from medical schools.

3. Members who have retired from actual practice. "In all instances, exemption may be allowed only if the member is also exempt from state and county medical society dues."

We have been asked if the $25.00 dues for 1950 includes Fellowship dues and the subscription to the JAMA. Fellows of the A. M. A., in addition to the $25.00, must pay $12.00 Fellowship dues and Journal subscription. This amount is the regular charge for the JAMA without Fellowship.

Membership in the A. M. A. is granted automatically to members of county and state societies. To become a Fellow, a member must submit a regular Fellowship form which is referred to the A. M. A. Judicial Council for determination as to eligibility.

Another question asked frequently is whether members can pay county and state society annual dues without paying A. M. A. dues, and still be retained on our membership roster. At the present time there is nothing in the By-Laws of this Society which refers in any way to A. M. A. dues. For the current year we are permitted to accept state society dues without A. M. A. dues, and retain the member on our membership roll. Whether or not this will apply next year is dependent largely on the actions of this House of Delegates. We are informed that there are a few component societies in Illinois which have set their county society dues for 1950 to include state society and A. M. A. dues. In these societies the problem of dropping a member for nonpayment is a local problem.

The A. M. A. House of Delegates may amend the present procedure at the national level when they meet in San Francisco in June.

Everyone realizes the value of the National Education Campaign in bringing to the people the story of compulsory health insurance and what it would mean to have a federally controlled medical care plan in operation. Thousands of resolutions passed by various groups and organizations throughout the country reflect the reactions of public opinion, not only as it affects medical care, but also as it affects hospital care and medical education.

A careful reading of the Annual Reports published in this Handbook will show what has been accomplished in this field by the active participation of this Society with the A. M. A. and other state and territorial societies. We have endeavored to impart as much information as possible in the columns of the Illinois Medical Journal during the past year, especially in its editorial section.

THE SECRETARY'S NEWSLETTER—Over a year ago we began sending out the monthly Secretary's Newsletter. It has become quite popular and we constantly have been adding new names to the mailing list until at this time, there are some four hundred mailed each month. Copies go to all component and branch society presidents and secretaries, members of the Council, etc. Anyone desiring to receive this Newsletter may do so by notifying the office to that effect.

We endeavor to put last minute information in the Newsletter, and it frequently is reprinted in component society bulletins which come back to the office. With more than 250 medical Journals and bulletins coming in to the office each month, we have a vast supply of material available. The Newsletter is largely the responsibility of the Secretary's Executive Assistant, Frances C. Zimmer.

THE NATIONAL EDUCATION CAMPAIGN—We have been constantly in touch with the headquarters office of the National Educational Campaign. Many thousands of pieces of literature have gone out to members of this Society from the Secretary's office. When we came home from the 1949 annual meeting we found more than a ton of this literature in our office sent us by Whitaker and Baxter. Packages were arranged and mailed to every county society secretary along with the large pictures of "The Doctor." The large pictures were too big to be sent by mail and had to be sent to every county in Illinois by express.

The educational campaign is a long term fight and must be continued. Fortunately we are no longer alone in this field. We have aligned with us many of the laity in addition to members of other professions —those professions allied with us closely in their work, and others who realize that after medicine is taken over, efforts will be made for the socialization of other fields. This has been true in other countries and it is reasonable to believe it would happen here if the first objectives are gained.

RURAL MEDICAL CARE—The Secretary's office receives many requests from small rural towns for a resident physician. Some of these small towns have lost their physician recently, or some elderly or disabled physician has retired leaving them without medical care. We are continuously making inquiries to determine the need and to determine whether or not the people really are denied adequate medical care. Some of these towns have not had a physician in residence since the horse and buggy days and it is doubtful if there is an actual lack of adequate care in the area.

Likewise we receive many letters from physicians desiring to find a suitable location. Some are recent graduates, while others are being released by the Army or Navy and want to relocate. We keep up to date mimeographed information on these towns in need of a physician and these lists are sent to physicians requesting such data. We also have a form which is sent out to these physicians which must be returned before our lists are available. In this way we are enabled to determine if the physician is qualified and would fit into the particular community in which he might be interested.

During the past year quite a number of physicians have gone into rural areas and many of them are well pleased with their choice. One of the men who attended the dinner meeting held in Chicago a year ago located in a relatively small Illinois town. He

is now completing his first year there, and has met with decided success. He has assured us that if a similar dinner meeting is held for interns and residents this year he would be glad to attend and tell these physicians what they can do in a rural community.

The first hospitals are opening which were built and equipped under the Hill Burton Act with local, state and federal funds. Quite a number are under construction in Illinois and others will be started in the near future. These new hospitals will solve many medical care problems in the communities where they are being erected. There are only a few areas in Illinois where people cannot reach a satisfactory hospital within a short time and where they cannot get a doctor for emergencies on short notice.

In most of the small Illinois cities there are as many (if not more) physicians practicing today than there were ten years ago. In some rural counties where there were three or more physicians in the small town during horse and buggy days, one physician can take care of the local needs today. Recently we attended a meeting in a rural community where there are now 14 physicians in the county while in 1900 there were approximately 50. Yet, with a modern hospital of nearly 100 beds and with several physicians doing major surgery, the people receive a high grade care and it is rarely necessary to send patients elsewhere.

THE SOCIETY—During the past year we have had, for the first time, a complete membership list mimeographed. Copies were sent to the A. M. A. to check with their membership records. We found quite a number of errors and we learned that we had been carrying some physicians as members who had moved out of the state, etc. This check became necessary in connection with the A. M. A. dues for 1950 and it will have to be continued in the future.

Many years ago the Society cooperated in the publication of a list of the physicians in Illinois with the State Department of Public Health, but this has been discontinued. A number of State Medical Societies publish a list of their entire membership in their Journals each year. This has not been authorized in this Society, and it would require a considerable amount of Journal space to give the names and addresses of nearly ten thousand members. However, if it should be the desire of this House of Delegates to have this list published, it will be done.

The total membership is approximately the same as it was last year. We have had members retire and move out of the state, but we have had quite a few come to Illinois from other states during the past year. It is impossible to state at this time just what effect on our total membership the payment of A. M. A. dues will have. It will require at least another year or perhaps two, to establish this definitely. This year there is no provision in either our By-Laws or those of the A. M. A. relative to the standing of physicians who pay county and state society dues but who do not desire to pay them to the A. M. A.

THE COUNCIL—The work of the Council continues to consume a considerable amount of time on the part of its members. Regular meetings have been held and it takes the major part of the day to get over the agenda. Your Secretary has attended all Council meetings, and it is his responsibility to keep the minutes of the deliberations. The minutes have been mimeographed and sent to each member after the meeting, and they have become more voluminous as time goes on.

Owing to the fact that the Journal has been filled with other essential material we have been unable to find space for the abstracts of Council minutes during recent months. However, this will be continued after the annual meeting. Attendance at the Council meetings is always excellent, and it is rare indeed that a member misses a meeting during the year.

DEATHS OF MEMBERS—Death, once more, has taken a considerable number of members of this Society during the past year. Time and space will not permit us to list all of the members who have died since the last annual meeting, but we will refer to some of those men who have been prominent in the activities of the Society in the field of medicine and medical care.

Harry J. Stewart, Oak Park, died February 17, 1950 at the age of 75. For many years Dr. Stewart was secretary of the Journal Committee and faithfully carried out the duties of that office. He was a regular attendant at the Journal Committee and Editorial Board meetings as well as at the annual meetings of this Society.

John S. Coulter, Chicago, died December 16, 1949 at the age of 64. For a number of years Dr. Coulter was responsible for the publication in our Journal of the abstracts on physical therapy. He was chairman of the Committee on Physical Therapy of this Society.

J. John Westra, Secretary of the Champaign County Medical Society, died July 17, at the age of 41. He was an outstanding secretary, and he made many talks before all types of lay groups on medical economic problems, and against compulsory health insurance.

E. Vincent Hale of Anna, Secretary of the Union County Medical Society, died recently at the age of 82. He was probably the oldest secretary in this organization, and faithfully carried out his duties over a period of years.

Donald W. Killinger, Joliet, died October 18, aged 48. For several years he was Secretary of the Will-Grundy County Medical Society, and at the time of his death, was president of that organization. He was a regular attendant at the annual meetings, and was always interested in the problems before the medical profession.

Frederick D. Culbertson, Rushville, died September 5, at the age of 67. Dr. Culbertson was a regular attendant at the annual meetings, and was well known throughout Illinois. About 25 years ago, he built a modern hospital in Rushville, which he maintained until his death. When he realized that he would be unable to continue in practice much longer, he offered to give the hospital, nurses home and all equipment to his home community. They were to make it a county-wide institution, and a vote was to be taken

within the county for a bond issue to considerably enlarge the hospital. Although Dr. Culbertson did not live to see final action taken, his request will be carried out.

Thomas B. Williamson, Mt. Vernon, died January 10, at the age of 65. He was the first chairman of the State Society Committee on Maternal Welfare, holding this position until his resignation on account of ill health. He too, regularly attended all annual meetings for many years, was president of the Southern Illinois Medical Society, and held several other positions.

Edward L. Cornell, Chicago, died January 31 at the age of 66. He was well known as a teacher, and an outstanding specialist in Obstetrics and Gynecology. Dr. Cornell appeared on many programs throughout Illinois, and the nation, and was a popular speaker.

Roscoe G. Leland, for many years headed the Bureau of Medical Economics of the A. M. A. and was well known to physicians throughout the country. He resigned on account of ill health and died October 17, at the age of 64.

Reid Owen Howser, Chicago, died May 17, 1949 at the age of 69. He was quite prominent for many years in the Chicago Medical Society, and the Illinois State Medical Society and was a regular attendant of their meetings. He maintained his practice in Oak Park for nearly 40 years.

Clarence O. Sappington, Chicago, died November 6, at the age of 69. A leader in the field of Industrial Health, Hygiene and Occupational Diseases, he was a member of the State Society Committee on Industrial Health for a number of years.

Other prominent members who have died since the last annual meeting are: D. E. Haworth, Beardstown, past president of the Cass County Medical Society; Lee C. Gatewood, Chicago; Joseph de Silva, Rock Island; Joseph Howard Beard, Urbana; William A. Hinckle, Peoria; T. A. Johnson, Rockford; Wm. C. Danforth, Evanston; Garret J. Hagens, Chicago; Ralph H. Wheeler, Chicago; Roy Ross Jamieson, Chicago; A. J. Roberts, La Salle; Hada Carlson, Moline; Perry H. Stoops, Ipava; John P. Denby, Carlinville; Norton Bowman, Flora; and Cecil Jack, Decatur. The list is too long to mention many others who have passed on during the past year.

On looking over the list of causes of death among physicians in Illinois, we once more find that heart disease in one form or other, was the greatest killer of all. Several died as the result of accident, and many were quite aged. Yet, most of these men remained in practice to the end. Their many friends and loyal patients will long remember them, and their efforts to relieve suffering humanity.

We again want to thank the county society secretaries and presidents, members of the Council, and other officers of this Society for their continued confidence and assistance in our many duties of the year. We have been most fortunate over the period of years, in having loyal, faithful workers in our offices, whose efforts have contributed much to make our duties easier, and we desire to thank them at this time. Most of our assistants will be present at this annual meeting, working as usual, and we hope that the members of this House of Delegates will become acquainted with them. A personal acquaintance will aid materially in their respective duties in the future. The office is always open six days of the week, and you may call upon us at any time.

## MEMBERSHIP DATA

| | |
|---|---|
| Members in Good Standing as of April 30, 1949 | 9,915 |
| Added during the year: | |
| New members | 379 |
| Reinstatements | 26 |
| Omitted in error | 3 |
| Total Added | 408 |
| Total | 10,323 |
| Dropped during the year: | |
| Died | 170 |
| Moved away | 149 |
| Resigned | 32 |
| Dropped for non-payment of dues | 101 |
| Expelled | 2 |
| Total Dropped | 454 |
| Net Total, April 30, 1950 | 9,869 |

## FINANCIAL REPORT OF THE SECRETARY

### Receipts from County Societies

| | | | |
|---|---|---|---|
| Adams | $ 540.00 | Hardin | 0.00 |
| Alexander | 180.00 | Henderson | 30.00 |
| Bond | 90.00 | Henry | 450.00 |
| Boone | 180.00 | Iroquois | 495.00 |
| Bureau | 635.00 | Jackson | 525.00 |
| Carroll | 210.00 | Jasper | 75.00 |
| Cass | 0.00 | Jefferson-Hamilton | 260.00 |
| Champaign | 1,770.00 | Jersey | 80.00 |
| Chicago Medical Society | 74,316.25 | Jo Daviess | 55.00 |
| Christian | 405.00 | Johnson | 60.00 |
| Clark | 110.00 | Kane | 2,560.00 |
| Clay | 150.00 | Kankakee | 970.00 |
| Clinton | 175.00 | Knox | 545.00 |
| Coles-Cumberland | 80.00 | Lake | 2,125.00 |
| Crawford | 95.00 | LaSalle | 1,215.00 |
| DeKalb | 540.00 | Lawrence | 365.00 |
| DeWitt | 250.00 | Lee | 340.00 |
| Douglas | 0.00 | Livingston | 235.00 |
| DuPage | 1,570.00 | Logan | 375.00 |
| Edgar | 225.00 | McDonough | 295.00 |
| Edwards | 60.00 | McHenry | 570.00 |
| Effingham | 240.00 | McLean | 1,045.00 |
| Fayette | 120.00 | Macon | 1,045.00 |
| Ford | 210.00 | Macoupin | 260.00 |
| Franklin | 600.00 | Madison | 1,085.00 |
| Fulton | 405.00 | Marion | 60.00 |
| Gallatin | 100.00 | Mason | 130.00 |
| Greene | 210.00 | Massac | 105.00 |
| Hancock | 200.00 | Menard | 110.00 |

| | | | |
|---|---|---|---|
| Mercer | 245.00 | Sangamon | 2,120.00 |
| Monroe | 0.00 | Schuyler | 80.00 |
| Montgomery | 40.00 | Shelby | 225.00 |
| Morgan | 790.00 | Stephenson | 440.00 |
| Moultrie | 0.00 | Tazewell | 30.00 |
| Ogle | 260.00 | Union | 200.00 |
| Peoria | 2,875.00 | Vermilion | 1,135.00 |
| Perry | 205.00 | Wabash | 120.00 |
| Piatt | 250.00 | Warren | 350.00 |
| Pike | 240.00 | Washington | 80.00 |
| Pope | 20.00 | Wayne | 105.00 |
| Pulaski | 55.00 | White | 100.00 |
| Randolph | 280.00 | Whiteside | 45.00 |
| Richland | 150.00 | Will-Grundy | 1,575.00 |
| Rock Island | 1,430.00 | Williamson | 450.00 |
| St. Clair | 1,700.00 | Winnebago | 2,062.50 |
| Saline | 240.00 | Woodford | 205.00 |

Total ..... $117,233.75

## RECEIPTS AND PAYMENTS

Fiscal Year Ended April 30, 1950

### RECEIPTS

| | | |
|---|---|---|
| Component Societies | | $117,233.75 |
| Subscriptions—Journal | | 358.70 |
| Advertising—Journal | | 56,753.98 |
| Exhibits—State Meeting (1949) | 3,180.00 | |
| Exhibits—State Meeting (1950) | 4,382.25 | 7,562.25 |
| Interest—Government Bonds | | 2,250.00 |
| Sale of Government Bonds | | 25,000.00 |
| Refunds on Advances, etc: | | |
| Annual Meeting Expense | 511.72 | |
| Medical Service and Public Relations | 676.00 | |
| Educational Committee | 300.00 | |
| Sale Medical History | 10.00 | |
| Miscellaneous | 61.95 | 1,559.67 |
| Total Receipts | | 210,718.35 |
| Cash Balance, May 1, 1949 | | 79,004.01 |
| Total | | $289,722.36 |

### PAYMENTS

| | |
|---|---|
| Secretary's Office Expense | $ 29,270.83 |
| Council Expense | 9,901.38 |
| A. M. A. Meeting Expense | 7,544.42 |
| State Meeting Expense | 17,378.66 |
| Society Exhibit Expense | 28.44 |
| Legal and General Counsel Expense | 500.00 |
| Journal Expense | 58,998.58 |
| Fifty Year Club Expense | 418.87 |
| Secretary to Committees—Chicago Office | 2,416.60 |
| House of Delegates Expense | 152.13 |
| Committee Expenses: | |
| Advisory Committee to Illinois Public Aid Commission | 45.36 |
| Advisory Committee to United Mine Workers | 298.73 |
| Committee on Archives | 2,112.61 |
| Educational Committee | 17,119.59 |
| Committee on Industrial Health | 168.21 |
| Committee to Investigate Prepayment Plans for Medical and Surgical Care | 362.13 |
| Maternal Welfare Committee | 622.87 |
| Medico-Legal Committee | 450.00 |
| Committee on Medical Service and Public Relations | 39,199.01 |
| Committee on Medical Testimony | 47.20 |
| Committee on Military Affairs and Emergency Medical Service | 45.76 |
| Postgraduate Committee | 2,369.72 |
| Committee on Rural Medical Service | 5,223.62 |
| Scientific Service Committee | 646.35 |
| Tuberculosis Committee | 149.39 |
| Women's Auxiliary | 264.97 |
| Social Security Taxes | 419.60 |
| State Unemployment Insurance Tax | 130.21 |
| Federal Unemployment Insurance Tax | 93.40 |
| Total Payments | $196,378.64 |
| Cash Balance, April 30, 1950 | 93,343.72 |
| Total | $289,722.36 |

Respectfully submitted, HAROLD M. CAMP, M.D.,
*Secretary-Treasurer.*

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Building
Rock Island, Illinois

May 3, 1950

To the Members of The House of Delegates:
Illinois State Medical Society:

## CERTIFICATE OF AUDIT

I have audited the accounts of the following for your Society for the fiscal year ended April 30, 1950:
Secretary's Office—Dr. H. M. Camp, Secretary;
Journal Office—Mr. L. E. Malley, Manager;
Educational Committee—Miss Ann Fox, Secretary;
Benevolence Fund—Dr. H. M. Camp, Secretary.

### SECRETARY'S ACCOUNTS:

Receipts: Dues received from Component Societies have been verified with duplicate receipts, the Master Ledger cards of each Component Society, and were compared with the Secretary's report.

During the year it was necessary to sell bonds amounting to $25,000.00 to provide additional cash. This amount is included in the receipts of your Secretary.

The Secretary collected $41,230.00 for the Benevolence Fund and $165,050.00 for American Medical Association. These amounts are not included in the Receipts as they are remitted monthly. The payments made are not included in the Cash Report of the Secretary.

Journal Receipts have been verified with the reports and records of your Manager, who collects the advertising receipts and remits same to your Secretary.

Bond interest received was compared with interest due from bonds. Other receipts consist of Exhibit Rentals, Journal Subscriptions, Refunds, etc., which have been taken into account as recorded.

All receipts are recorded on the Secretary's records and deposited in the depository bank.

Payments: Payments are made by check and are supported by approved vouchers, orders, etc.

The cash balances were reconciled with the depository bank statements.

The Society has invested funds amounting to $90,000.00 in U. S. Government Bonds, which are issued in the name of the Society. The Society also has 31 and 70-100 shares of common stock of the Chicago and Northwestern Railway Company. This stock was issued in lieu of the bonds formerly held.

The accounts of the various departments have been well kept and in my opinion your Secretary's report represents the true cash transactions for the year.

The Council is furnished with a detailed audit report which agrees in totals with your Secretary's report.

Respectfully submitted, FRED N. SETTERDAHL, *Certified Public Accountant.*

## REPORT OF THE CHAIRMAN OF THE COUNCIL

The past year has without doubt been the most critical of this first century of our existence. We have been and are faced with a well planned determined effort to change our whole manner of living. A plan to place in the hands of politicians the control of the sick and those who minister to their needs. A plan to make of the physician, with his heritage of freedom to treat the sick as his teaching and experience dictate, a hired man of the State making innumerable reports to bureaucrats, and instead of spending spare moments studying recent developments in the field of medical practice must spend hours in familiarizing himself with the constantly changing directions of a medical czar. It is pleasant to note that during this year an equally determined effort has been made to oppose this vicious encroachment on our profession. The busy members of our Council from all parts of the State, being alert to our needs, give constantly of their time and energy whenever and wherever called upon. Members of the Council have been more than faithful in attendance at Council meetings. Six sessions have been held during the past year, all except one being held in the Palmer House, Chicago. The January meeting was held in Springfield. In large organizations, such as the Illinois State Medical Society, a great load must of necessity fall upon special committees. These we can say have functioned conscientiously and well and are deserving of the thanks and commendation of the House of Delegates, and so brief mention should be made of their activities.

WOMAN'S AUXILIARY—The Advisory Committee to the Woman's Auxiliary with Dr. Pond and Dr. Scatliff as co-chairmen have kept a close working agreement with the women. Several meetings have been held and also frequent telephone interviews. They have been alert to the dangers of compulsory health insurance and are taking a leading part in arranging for speakers to appear before various groups in opposition to this strange movement. They have maintained their interest in the Benevolence Fund and in one branch in Cook County have contributed more than two thousand dollars to this worthy cause. Their interest in the History of Medical Practice in Illinois is outstanding and will contribute much to the success of this enterprise.

JOURNAL COMMITTEE—The Journal Committee has had the usual problems to deal with the past year. The cost of labor and materials have become fairly stabilized. The same may be said of salaries. A few criticisms and suggestions have come into their offices. Since the members of the Society are interested in maintaining and supporting a first class publication, Dr. Hedge, Chairman and President-Elect of the Society, who has guided the work most efficiently, is always ready to welcome suggestions and constructive criticisms. Harry Stewart, long-time faithful and efficient secretary of this Committee passed away in February and was succeeded by R. C. Oldfield, also of Oak Park, who we believe is a worthy successor of Dr. Stewart and an excellent addition to this Committee.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS—The Committee on Medical Education and Hospitals has been a stabilizing influence again through another year. Their work with the medical schools of Chicago has been outstanding and has been a definite means of establishing a fifth school of medicine in Chicago that will no doubt become a credit to the community. Difficult matters submitted to them for adjudication have been handled most tactfully and considerately. Dr. Thompson and his Committee should be congratulated.

COMMITTEE ON TUBERCULOSIS CONTROL—The Committee on Tuberculosis Control, whose chairman is Dr. F. M. Meixner, is continuing the excellent work which was instigated in the Chicago Medical Society under the direction of Dr. James Hutton. The story is long and interesting. The members of the Chicago Medical Society for a number of years have been content with what seemed to be good control of the tuberculosis problem, but it was suddenly brought to their attention that tuberculosis was definitely on the increase and that something definite should be done about the matter. The Council of the Chicago Medical Society appointed a committee on tuberculosis eradication and made Dr. James Hutton and Dr. Robert Berghoff co-chairmen. This Committee was something besides being just an ornament. Stimulated and inspired by its co-chairmen, many neglected situations were uncovered and helpful changes made in organizations that had to do with the care of tuberculosis. These need not be mentioned in detail except to say that marked changes have taken place in the tuberculosis sanitarium and a Suburban tuberculosis district has been established in Cook County with Dr. Piszczek as its head. In addition, an active case finding program is carried on throughout Cook County by mobile x-ray units in strategic areas. Hospitals are being urged to

x-ray all admissions, and in some instances are providing bed care for tuberculous patients. Ground for the large 450 bed structure in the West Side Medical Center has recently been broken, while the hospital at Mt. Vernon is nearing completion. We do feel that the work of this Committee is bearing rich fruit.

COMMITTEE ON CANCER CONTROL—The cancer problem is so vast and complicated that it sometimes seems impossible of solution. Fortunately we do have men with ability, patience and courage to carry on. It is said of the marines that they have a saying which is very appropriate and which we might all adopt to our great advantage: "The difficult we do at once. The impossible takes a little longer." Much good work is being done by Dr. Warren Cole and his committee. His report to the House of Delegates should be carefully read by all of us.

POSTGRADUATE AND SCIENTIFIC SERVICE COMMITTEES—Since it is so difficult and almost impossible for a busy doctor to keep abreast and to keep informed about the new developments in the fields of medicine (diagnoses, therapy, etc.), and since the prime function of all medical organizations is educational, we are fortunate in having active committees with a capable chairman of the Scientific Service and Postgraduate Committees. These Committees have done yeoman service for the Society these many years. Meetings are held in each Councilor District every year and at this time plans are being made for more and better meetings next year. The work of Robert Berghoff and his Committee has been so outstanding that our thanks and commendations go to them wholeheartedly.

VOLUNTARY PREPAYMENT PLANS—Dr. Hopkins has carried the torch for voluntary prepayment plans for medical and surgical care and with his Committee an excellent job is being done. Five commercial insurance companies have entered the field along with the Blue Cross and Blue Shield to give moderately priced and good insurance to everyone. We think this is a splendid piece of work and doubtless one of the most efficient ways that compulsory health insurance can be avoided. The great and rapid increase in the number availing themselves of this voluntary insurance is in a large measure due to the efforts of this Committee which should have our congratulations and active support.

COMMITTEE ON NUTRITION—The Committee on Nutrition with Dr. G. C. Otrich as its chairman finds difficult going sometimes. This Committee is obliged to map its course with very little precedent as a guide. The importance of this work is without question. Malnutrition is doubtless a cause of many ills and defiiciencies in food supplies have many times been the cause of a nation's downfall. Soil conservation in the next few years will become more and more important. To provide a soil that would produce the essentials in good food means study by chemists and experts in nutrition, and farmers need to be instructed as to the rotation of crops. It has been said that poor land makes poor people. Our nation is no different than others and, if we are to survive as virile active healthy people, it is necessary to maintain a high state of nutrition for all. Probably, medical care comes second to good nutrition. Treatment by diet as the years go on is bound to become more and more important and, if this Committee can stimulate interest in the subject among medical men as well as the laity, it will deserve great credit for its efforts.

VETERANS ADMINISTRATION—The question has arisen in the Council relative to the Veterans Administration and changes which might be contemplated. A recent report from Dr. Hopkins, Chairman of the Advisory Committee, seems to indicate that at this time no plans for making any changes in the care of veterans or payment for services are in the making.

COMMITTEE ON INDUSTRIAL HEALTH—The marked industrialization of our country since the Civil War has been of such tremendous proportions as to be almost unbelievable. With this industrialization bringing in its wake a large number of accidents and also problems of many health hazards, it became necessary that medical men be interested in these changes. Not many years ago the industrial surgeon was looked upon as a stepchild of the medical profession. Later came rapid transportation—automobiles, airplanes, etc., producing many serious injuries. These also fell into the hands of the industrial surgeon and make of him a very important part of surgical and medical care and it is pleasant to note that with these changes the industrial surgeon has again found his proper place among his colleagues. Dr. Chivers, Chairman of the Committee on Industrial Health, has taken a large part in bringing about this improved relationship. He has been in attendance at national meetings of this organization and submitted interesting reports of the progress being made. We believe this to be an important part of our medical service.

COMMITTEE ON MILITARY AFFAIRS—Dr. Blair and his Committee on Military Affairs and Emergency Medical Service are constantly alert to political and economic conditions as they arise from time to time. In this strange world with many "A" bombs and the "H" bomb in its early stages, it is vitally necessary that a Committee such as this should be continually studying and preparing for emergencies that may arise. We may only hope that our statesmen may be able to avert any and all political catastrophes which would so markedly increase the work of this Committee.

COMMITTEE ON ARCHIVES—The Committee on Archives with Dr. Monroe as chairman continues to add an increasing amount of material to our store of interesting records. It is to be hoped that some time a permanent repository for these valuable historical papers may be provided by the Society.

EDUCATIONAL COMMITTEE—The Educational Committee created in 1922 has done excellent service for the Society these many years. Every year new and greater accomplishments have been achieved. Since the advent of television, a new and effective instrument has been added to its armamentarium. In February, 1950,

the Committee launched a new series of weekly radio transcriptions in cooperation with WFJL, Chicago FM Station, titled "Your Doctor Speaks." This Committee has had the task of editing and criticizing script material submitted by physicians invited to participate. This has been so popular that medical organizations out of the state have asked for the service. "Health Talk" has become increasingly popular with some 350 papers using it as a regular feature. Providing speakers for health talks before clubs, churches, schools and other groups continues as an active part of their program. Dr. Charles P. Blair, Chairman, with the very active assistance of Miss Ann Fox and the members of his Committee are to be congratulated for their excellent work as well as for grasping every opportunity to enlarge and expand its usefulness.

COMMITTEE ON MEDICAL HISTORY—The Committee on Medical History with Dr. James Hutton at its head is actively engaged in preparing the history of medical practice in Illinois down to 1900. An active, interested Committee is working on it with Dr. D. J. Davis, Permanent Historian, contributing valuable material. A large quantity of material is being assembled and we might compliment the Woman's Auxiliary on its part in this project. The material will eventually be arranged to make it readable and interesting. We are all so close to important events that we are unable to properly evaluate their significance so those who follow us in twenty-five or fifty years should find much material that may serve a useful purpose in the guiding and planning of the problems of their day.

ILLINOIS PUBLIC AID COMMISSION—It has been the good fortune of the chairman of the Council to meet with Dr. Coleman and his Advisory Committee to the Illinois Public Aid Commission which tries to solve the problems of the chronically ill and the indigent of the State. There has been the question of marked decrease in funds as well as sometimes chiseling both on the part of the physicians and the part of the patients. Dr. Coleman could well be congratulated on the tactful manner in which these problems are considered.

The United Mine Workers have also received the careful attention of Dr. Coleman and his Committee. We are assured that the cooperation between this group and the mine workers has continued with perfect and complete understanding.

RURAL MEDICAL SERVICE—The Committee on Rural Medical Service with Dr. Harlan English as its chairman is doing a splendid job in maintaining fine public relations. Their meeting with the representatives of the State Agricultural Association at the Palmer House in the fall was an outstanding success. This Committee is taking advantage of its fine opportunities to make friends for our Medical Society. In cooperation with the State Agricultural Association, they are now maintaining eleven students in their medical studies at the University of Illinois, two of whom will be ready to enter the practice of medicine in 1952.

PHYSICAL THERAPY—It is with sorrow that we note the death of John H. Coulter who was for many years the Chairman of the Committee on Physical Therapy. Over a period of years, he was a fine influence for good. It is our hope that the Committee will function in its usual efficient manner.

DEPARTMENT OF PUBLIC HEALTH—Dr. Roland R. Cross, Director of Public Health, is always found in his place at our regular Council meetings. Little wonder that he has sometimes been regarded as an actual member. However, we would say that it would be difficult to properly organize the Council for the transaction of business were he not present. The Council as well as Dr. Cross might be congratulated on the fact that the relationship has been so cordial and that this relationship tends to activate and improve all health and hospital measures that are becoming more and more efficient throughout the State.

FIFTY YEAR CLUB—The Fifty Year Club continues to prosper under the leadership of Andy Hall. This group has grown in number and influence from year to year. All seemed to have found for themselves a place in the Society and from our observation their membership is a source of a great deal of pleasure. Their annual dinner is an historical event and from year to year the attendance increases. Dr. Hall's achievements are a source of pride and inspiration to every man in the Society. They need not be recounted here but few men in the field of medicine have attained to such distinction.

APPOINTMENTS DURING THE YEAR—It is a pleasure to note that no necessity for adding new committees to our working force has arisen the past year. However, we have been asked to provide representation in groups, medical or quasi medical, already operating in the State. Dr. L. R. Davenport, Consultant in Veterinary Medicine requested a representative from our State Society to the Committee on Public Education on Animal Diseases Transmissable to Man. Dr. G. C. Otrich consented to serve on this Committee. Mr. Fred K. Hoehler, Director of the State Department of Public Welfare, asked the Council to name a representative to serve on a State-Wide Committee to study various measures that might be adopted which would affect the mentally ill, state hospitals for the insane, penal and corrective institutions, etc. Dr. Garm Norbury accepted this appointment.

MEDICAL SERVICE AND PUBLIC RELATIONS—John Neal and his Advisory Committee have rendered excellent service. Mr. Neal spent much time providing information to the membership at large relative to legislation the past year in Springfield. He was able to analyze proposed measures as they affected the medical profession and our relations with the public. This gave all of us a basis from which we could advise, criticize or commend our representatives in the legislature. And may I add that to become a good legal counselor, one should have for his immediate ancestor a good doctor, as is the case with Mr. Neal.

To place a proper value on public relations is not always easy or simple, but we have noted a definite improvement in this regard since Mr. Leary has taken over this task.

The work of this Committee under the chairmanship of Percy E. Hopkins has been outstanding. His ability

and interest has contributed much to the success of the activities.

GENERAL INFORMATION—The work and activities of the Society continue to grow in volume and importance from year to year and, if we continue to make progress, this will go on indefinitely. In the past ten years, the Educational Committee has increased its activities and its usefulness many fold. Its value to our Society and our State cannot be measured by any known standard. The Benevolence Committee is trying to fill a place in the lives of our colleagues which it is hoped may make the world just a little better place in which to live. The Committee on Rural Health is establishing itself on a basis that will make for better medical care and better health and thus for better public relations for all of our people. Others could be mentioned but let this suffice.

All of these activities require the attention and the supervision of a good and competent secretary which we are fortunate in having in the person of Dr. Harold M. Camp who carries this Herculean task with courage and efficiency. How does he do all this? How does he carry this load with a multiplicity of offices and spending long hours in commuting? There is no answer. Dr. Van Dellen has given splendid service as Associate Editor. His employment should be hailed as a matter of good judgment on the part of the Council. Mr. L. E. Malley as Business Manager of the Journal continues to render efficient service. In a long range planning, it would seem that the Chicago Medical Society with the State organization could well combine their efforts and resources in securing a building properly located where office space would be adequate, where specialty societies and other groups could meet and where proper arrangements could be made for growth and expansion, for storage of records and archives, for reading room, library and museum, and the many other needs required by organized medicine in this State. All of this could be accomplished without loss of identity by any organization. At this time unfortunately there is nothing in the foreseeable future that this hope can materialize, but it is safe to predict that some one some time will recognize the great advantage of such an arrangement.

After many years of continuing interest in medical education and organizational activities, one develops an affection and esteem for the organization as well as its individual members that it may and indeed does become a part of one's life. The Council has been kind and understanding at all times of the shortcomings and inefficiencies of its chairman, which has made the work both interesting and pleasant throughout the year. Observing immediate predecessors has been very helpful. Our President, Dr. Walter Stevenson, is an inspiration to everyone. The past year he has traveled the length and breadth of the State carrying the message of anti-socialism and anti-compulsory health insurance. He has appeared on more than three score platforms with his message of hope and courage that we may not fall into the hands of a socialist or a communist regime. He should have our heartfelt thanks and commendation.

We are promised a very fine meeting in Springfield this year. Dr. Reisch and his committee on Arrangements are leaving nothing undone that will make it one of the best in our long history. Chicago has been proud and happy to be hosts to the Society these past difficult years when transportation and hotel facilities were none too good, but as we near more normal times in this respect, our State Capital with all its traditional history of State as well as National growth, should give us inspiration and courage to carry on the good work of maintaining and enlarging that freedom of thought and action for which our fathers fought and died. And so we look forward to another Springfield meeting with pleasure and great satisfaction.

Respectfully submitted, OSCAR HAWKINSON, M.D., *Chairman of the Council.*

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### REPORT OF THE COUNCILOR OF THE FIRST DISTRICT

It is again time for the Annual Report, and my report will be brief this year. The First District has had a rather uneventful year. Things seem to go on with little friction, and all is peaceful at this time.

During the past year we have had a little difficulty in one of our River Counties, but that was settled in a very satisfactory manner, and I believe all is harmony once again.

The Societies are functioning in a good manner, and having some very interesting programs—in my District some of the Societies meet monthly, and others every two months.

I have attended several of the meetings, and find them very instructive, and there seems to be a very good spirit among the membership.

There has been some dissension over the A. M. A. dues, but I believe that education as to the purpose of the assessment will iron out that difficulty.

We are having a Postgraduate Meeting in Aurora on March 29, 1950, and as it looks now, it will be quite a worthwhile meeting.

My best wishes to the District and to the State Society for the coming year.

Respectfully submitted, L. J. HUGHES, M. D., *Councilor of The First District.*

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### REPORT OF THE COUNCILOR OF THE SECOND DISTRICT

The past year in the Second Councilor District has been an active one. Two 50 year memberships have been presented in the District. During the year new branches of the Woman's Auxiliary have been formed; one in LaSalle County and one in the combined counties of Lee and Whiteside. Your Councilor has visited each one of the component societies in the district and has found the affairs of each one in good order. Your Councilor has attended all Council meetings during the year and has derived a great deal of benefit from his association in the Council. A postgraduate conference was held in LaSalle on March 23rd and was fairly well attended.

Respectfully submitted, JOS. T. O'NEILL, M. D., *Councilor of the Second District.*

## REPORT OF THE COUNCILORS OF THE THIRD DISTRICT

Chicago was founded in 1833 and the Chicago Medical Society began seventeen years later in 1850. Remarkable developments have occurred in medicine in the last 100 years and particularly in the last generation. Chicago has played its part in this development and has become one of the great medical centers of the world. At the end of the first fifty years the membership of the Chicago Medical Society had grown to 1,000. This Centennial Year, 1950, the Third District has for its constituency more than 6,000 physicians who in fifteen branches constitute the Chicago Medical Society, the Medical Society of Cook County. On March 1st of this year, 4,000 physicians paid their dues in full. A certain amount of confusion has arisen concerning the American Medical Association dues but no doubt will be straightened out within the near future.

During the past year combined scientific and business meetings have been held from October through May by each of the component branch societies. The Central Society held scientific meetings during these months at the John B. Murphy Memorial where some of the country's most outstanding speakers addressed the Society members on subjects of current interest and importance. The Council also met regularly to carry on the business of the Society and upon call when matters of great importance became urgent.

The Chicago Medical Society is very conscious of its obligations to the profession and to the public. It has attempted to fulfill this obligation through every possible source and it is a pleasure to bring to the House of Delegates of the Illinois State Medical Society a short resume of some of these activities.

ANNUAL CLINICAL CONFERENCE—The Sixth Annual Clinical Conference held at the Palmer House in Chicago, February 28th through March 3, 1950, celebrating the Centennial of the Society was an outstanding success. There was a total registration of 6,200 of whom 3,758 were physicians, representing 31 states, Canada, South America, Switzerland, Greece and Yugoslavia, 676 of Allied Professions (Nurses, technicians, pharmacists, etc.), 61 Scientific exhibitors, 735 technical exhibitors and 993 guests (including senior medical students) attending the Conference.

The scientific program was most attractive in that it covered many phases of medicine which at this time are of special concern to physicians. The speakers were selected from the large medical centers of the country and the material they presented before capacity audiences indicated that physicians are eager to bring themselves up-to-date. The round table discussions at noon were stimulating to those attending and the panels at the close of each afternoon were extremely popular.

The scientific exhibits were presented by medical schools, hospitals and individual physicians. Many of these exhibits were shown for the first time and attracted a great deal of attention. The technical exhibits filled the large exhibit hall which was crowded during the intermissions. Those in charge of these exhibits were most enthusiastic over the many physicians attending.

As an added feature to the Conference, Color Television was presented through the courtesy of Smith, Kline and French Laboratories and St. Luke's Hospital. This represented another great step forward in medical education and the Chicago Medical Society felt privileged to bring color television to this Conference.

It is significant that the Conference during the Centennial Year was the largest medical meeting ever sponsored by the Chicago Medical Society and it is indicative of the growth of the Society and promises well for the future of organized medicine in Cook County.

PERMANENT HOME—The permanent home project of the Chicago Medical Society has had more than difficult going during the past year. It was generally believed at one time that a suitable building in the West Side Medical Center might sometime be erected. It was hoped that this might house the offices of the State Society as well as other interested organizations. At this time, it would seem that the membership is not ready to make the necessary effort and other generations must then take up the burden being laid down by those now in its promotion.

AMERICAN CANCER SOCIETY—The slogan "Every Doctor's Office a Detection Center" has been the keynote of the public and professional education activities of the American Cancer Society in Cook County.

Two Information Centers are now functioning in Chicago and Cancer Detection Centers have been in operation at the Women's and Children's, Grant, Loretto, Henrotin and Mercy Hospitals. These centers provide facilities for a thorough physical examination of apparently well persons for signs of cancer with referral to the family physician. Diagnostic and Cancer Clinics are in operation at the Norwegian-American, St. Bernard's, St. Luke's, Mercy, Ravenswood, Little Company of Mary Hospitals and at the Northwestern University Clinic.

A year's subscription to the "Cancer Bulletin", an outstanding professional publication, was given to 6,000 members of the medical profession in Chicago.

The program of professional education has been continued with marked success. A five day refresher course was held during January, 1950, at Northwestern University Medical School, the University of Illinois College of Medicine, Loyola University (Mercy Hospital), the University of Chicago School of Medicine and Michael Reese Hospital. This course provided expert instruction in the early diagnosis and treatment of cancer in every part of the body.

The cancer exhibit at the Museum of Science and Industry was opened in April, 1949, and has been visited by well over 206,000 people who have also seen the movies on cancer provided by the American Cancer Society.

Because Chicago is one of the Country's outstanding medical centers, a good portion of research funds of the Society are channeled into Illinois. Investigators at medical institutions of Chicago have been given grants-in-aid for clinical research. Further aid to the professional medical man was given through a grant to the

Crerar Library for the purchase of cancer literature. The library now has 90 per cent of all journals of current importance in the cancer field which are available to physicians and scientists specializing in the disease.

PUBLICATIONS OF THE SOCIETY—In keeping with the 100th Anniversary of the Chicago Medical Society, the format of the weekly Bulletin of the Society has been improved and has met with general approval of the membership. The Bulletin carries most of the papers presented at the Clinical Conferences and some of the postgraduate papers. It goes to all members of the Society and to a large exchange list of county societies throughout the country and has a weekly circulation of 7,500.

The papers presented at the Clinical Conferences have been published in book form and may be purchased through the Society office. The Proceedings offer a valuable addition to the medical library of any hospital or individual physician.

In view of the fact that the Chicago Medical Society is one hundred years old, a history of the Society and the growth of medicine in Chicago is being prepared. This is being done by a graduate student from the History Department of Northwestern University. Through the action of the Trustees of the University, Mr. Thomas N. Bonner was given the award "Chicago Medical Society Fellow in Medical History." The information contained in the final publication will be a great addition to the archives of the Illinois State Medical Society whose Committee on Medical History has cooperated with that of the Chicago Medical Society.

The Chicago Medical Society issues a weekly publication, "This Week in Chicago Medicine," as a service to the medical profession of the country. This publication includes information concerning meetings, lectures, clinics and conferences in the medical schools and hospitals of Cook County which are of interest to visiting physicians. Programs and meetings of all medical and special societies are also furnished in this listing.

Information is classified by days and hours and is helpful to visiting physicians, surgeons and specialists who come to Chicago for a day or longer for observation or refresher work. The listing is sent each week to all hospitals in Illinois as well as to the medical libraries in the state. Illinois physicians are urged to consult this listing before coming to Chicago or to obtain a personal copy by writing the Chicago Medical Society at 30 North Michigan Avenue or by a call at the office upon arrival in the city. "This Week in Chicago Medicine" will prove extremely helpful in planning a stay in Chicago and will be a great time saver.

COOK COUNTY HEALTH SERVICE—The special committee appointed to study The Chicago-Cook County Health Survey conducted by the United States Public Health Service reports that progress has been made during the past year and that many recommendations made in the Survey are already in operation.

POSTGRADUATE COURSES—The Chicago Medical Society in 1947 offered its first two postgraduate courses which proved to be highly successful. Similar courses were again offered in 1948 and 1949. Each year the registration has increased and the number of states represented in the registrations has widened. In 1949 a total of 233 took the courses, 102 attending the course in Cardio-Renal and Peripheral Vascular Diseases representing seventeen states, Canada and Hawaii and 131 taking the course in Obstetrics, Endocrine-Gynecology and Sterility from twenty-four states, Canada and Hawaii. Forty-five physicians attending the 1949 courses had taken the 1947 or 1948, or both courses.

These courses offered by the Chicago Medical Society seem to fill the need and the demand of physicians who wish to take short, intensive work with outstanding faculties from all medical centers of the country. Two comments from physicians attending indicate the interest and value of this type of postgraduate medical education: "Excellent. Words cannot express my privilege to attend. It is the best I have had in spite of postgraduate work in universities in this country and Europe." "Excellent, well planned, well executed. Every physician should avail himself of these courses yearly."

Two intensive postgraduate courses will be given this fall at Thorne Hall, Lake Shore Drive and Superior Street. The week of October 23-October 27 will be devoted to "Diseases of the Gastro-Intestinal Tract, Liver and Pancreas." A course in "Diseases of the Heart, Kidney and Blood Vessels" will be offered the week of October 30-November 3. Prominent teachers are being secured for these two courses which are open to all physicians who are members of their county medical societies.

CHILD HEALTH COMMITTEE—The Child Health Committee has been extremely active during the past year under the leadership of Dr. John L. Reichert. In 1949 the Committee was reorganized to represent all medical volunteer agencies interested in school health, particularly the Chicago Medical Society, the Chicago Pediatric Society and the Institute of Medicine. The chairman has been active in the development of a Joint Committee on Health Services for the School Child, a comprehensive school health council composed of about 30 agencies and representing over 1,000,000 people. Medical activities are undertaken by this group only with the approval of the Chicago Medical Society Child Health Committee.

It is a pleasure to report that there has recently been appointed, largely through the efforts of this Committee, a School Health Director in the Chicago Public Schools. The Chicago Medical Society Committee set up standards for this position, it screened all available candidates for the position of Director, and is prepared and expected to serve the new Director in an advisory capacity.

Through the plan developed by the Child Health Committee in its work with the Parent Teacher Associations for taking care of the examinations of preschool children, great progress has been made and the number of children having examinations by their own

family physicians has increased. The Committee has stressed the fact that the examinations at the schools should be "clean-up examinations" for those not having family physicians. The plan has functioned well throughout the city during the past year and has been acceptable to the individual physicians, the parents, and the schools because it has improved the quality of the examinations given.

The policy of the Committee is to continue working toward better school health with emphasis on the key position of the family physician in all phases of the developing school health program.

WOMAN'S AUXILIARY—There will be a separate report from the Advisory Committee to the Woman's Auxiliary. Through the cooperation of this Committee, the Society has enjoyed good relations with the Woman's Auxiliary which has had a splendid year. Their work indicates that they can do a great deal in promoting good public relations for the doctor and they are all eager to see that the Society activities remain in the forefront.

PRESS RELATIONS—The Chicago Medical Society enjoys an excellent working relationship with the newspapers and press services of Chicago. Each year a meeting is held with representatives of the news services and this close relationship has resulted in a better understanding of each others' problems and willingness to cooperate.

VOLUNTARY PREPAYMENT MEDICAL PLANS—In 1949, the Blue Shield Medical-Surgical Plan of the Chicago Medical Service rounded out its first full calendar year of operations. This plan was organized in Cook County on November 24, 1947 by the Chicago Medical Society and was offered as a companion plan to Blue Cross Plan for Hospital Care.

No members were enrolled during 1947 or the first four months of 1948. This time was devoted to setting up organizational and administrative procedures and seeking the cooperation of participating physicians. By May, 1948 when the Plan began to enroll members, approximately 5,000 physicians had signed as participating physicians to support the Plan.

The first group to enroll in the Blue Shield Plan were the employees of the Chicago Tribune, whose membership became effective on June 27, 1948. The employees of the Board of Education were next in line to enroll. At the end of 1948, the Plan had 19,674 members.

During the year 1949, the Blue Shield grew rapidly and by December 31, 1949, 535 Blue Shield groups with 143,530 members enrolled. In 1949, medical services for Blue Shield members amounted to $498,395.47 and it is estimated that over $1,000,000 will be paid to doctors during the year 1950.

Among the well-known companies which sponsor Blue Shield for their employees are: Allied Chemical & Dye Corporation, Board of Education, Chicago Tribune, E. I. DuPont de Nemours, Diamond Match, Esquire Corporation, Illinois Bell Telephone, Mandel Brothers, Milwaukee Railroad, Northwestern University, Northwestern Railroad, Parke Davis, Swift & Company, Union Carbide and Carbon Company, U. S. Rubber Company.

In this short period of time of less than three years since the Plan was introduced, this nonprofit, prepayment plan organized and sponsored by the Chicago Medical Society, had gained merited recognition for services to both the physicians and its members.

The success of this Blue Shield Plan in so brief a period of time in the Chicago area, resulted in many requests from other county medical societies throughout the state to be allowed to participate in the Plan. By December 31, 1949, a total of 20 medical societies outside of Cook County had signed and formed Blue Shield Plan Units, and 18 of these had signed up the required 51% of the doctors in their respective counties as participating physicians.

Because the scope of services of the Chicago Medical Service Blue Shield Plan had been extended outside the Chicago area, it was deemed advisable to consider changing the name to the Illinois Medical Service in anticipation of establishing Blue Shield on a state-wide basis through individual county medical societies. Therefore at a meeting on December 1, 1949, subscribers were asked to vote on the advisability of changing the name from Chicago Medical Service to the Illinois Medical Service. The name change was authorized and has been approved by the Illinois State Department of Insurance. The original charter was amended so that the new name became effective officially as of January 6, 1950.

The extension and organization of Blue Shield in many more counties throughout Illinois is now under way, and it is anticipated that membership in Blue Shield will be more than doubled before the close of 1950.

The services that Blue Shield is rendering to the people is an outstanding example of free enterprise. The plan is administered without red tape, under the direction of doctors. Members of the Plan choose their own doctors, and the patient-doctor relationship is kept inviolate.

Over 15,000,000 persons are enrolled throughout the country in 58 Blue Shield Plans, representing a maximum growth of 5,300,000 members in 1949. This phenomenal growth demonstrates the popularity of the Blue Shield Plan and the fact that it meets a real human need.

Many committees of the Chicago Medical Society have cooperated with similar committees of the Illinois State Medical Society during the past twelve months and their reports are included in the committee reports appearing elsewhere in the handbook.

Respectfully submitted, WALTER C. BORNEMEIER, M.D., WADE C. HARKER, M.D., OSCAR HAWKINSON, M.D., H. PRATHER SAUNDERS, M.D., F. LEE STONE, M.D., ARKELL M. VAUGHN, M.D., *Councilors of the Third District.*

## REPORT OF THE COUNCILOR OF THE FOURTH DISTRICT

It is a pleasure for the Councilor of the Fourth District to report to you at this time. Professional relationships in the counties has been unusually smooth.

The enlightenment of the lay citizens of the district in matters pertaining to the economics of medicine has been very successfully attended to, often in an indirect fashion rather than direct, but withal very effectually.

No problems of actual disciplinary action have appeared. It is a strange fact that lack of knowledge of the tenets of the Constitution and By-Laws of the local societies on the part of the members has on two occasions permitted much comment and furor. It is quite probable that other districts have had the same difficulty. Your Councilor has made an especial effort to urge the membership to become familiar with the Constitution of their Societies. Knowledge of the Constitution and By-Laws will iron out most problems and enable the dealing with personal problems without rancor or fear of being individualistic. Let's all KNOW what we belong to.

Due to the fact that the cities of Peoria, Rock Island, Moline, and East Moline lie in this district, the number of scientific meetings is quite numerous and the calibre of the programs is quite above the average. This fact enables these local societies to secure many out of the state speakers of national eminence.

Your Councilor has attended all meetings of the Council for the year. He has served as a member of the Executive Committee, the Finance Committee, the Prepayment Insurance Committee, the History Committee, and as Chairman of the Educational Committee.

There are several radio stations within the district and the local societies have interested themselves in evolving medical programs for the stations in order to offset any unwarranted narrations which occasionally filter into programs of stations that have no liaison with organized medicine. This is done by securing proper ethical clearance for the program and has served indirectly to secure the station's good will for each of the local members.

One of our local societies, Rock Island County Medical Society, had in operation a Prepayment Insurance plan, which has attained excellent success. The plan is in complete accordance with our state plan but operated locally alone.

Your Councilor desires to express his great appreciation and pleasure to act as representative from this district. It has been very pleasant and instructive to associate with other members and the officers and the Council and to have the hearty cooperation of the officers and individual members of the various local societies which they have accorded me.

Respectfully submitted, CHARLES P. BLAIR, M. D., *Councilor of the Fourth District.*

## REPORT OF THE COUNCILOR OF THE FIFTH DISTRICT

The Fifth District comprises eight counties three of which are small in size and have only a few physicians. In these counties meetings are irregular as it is difficult to get physicians to attend. In the other five counties meetings have been held regularly. Programs have been good and attendance satisfactory.

Membership in the Societies of the Fifth District is the highest it has ever been. Many physicians are still reluctant in speaking to lay groups but are doing good work among their own patients and are cooperating in the program of the American Medical Association. Criticism of the profession has resulted in greater interest in medical organization and a realization that if we are to prevent the control of medical practice by the politicians then the rank and file of physicians in active practice must show more interest in medical organization and endeavor to enlighten their patients on medical problems and policies.

During the past year two Postgraduate Conferences were held in the District, one in Springfield and one in Pekin. This is the first time a conference has been held in Springfield. In both instances the programs were excellent and the attendance good.

Hon. Leslie C. Arends, Congressman from the 17th District recently sent a letter to all physicians in his District. He made some very constructive suggestions to the physicians and urged them to become active in politics as a defensive measure to help preserve the freedom and liberties which the American people have enjoyed. We believe these suggestions are valuable and trust that some members of the profession may become candidates in both state and national legislative bodies. A few capable conscientious physicians in public office could do much to mold legislation.

It is suggested that every physician review the voting record of his representatives in the Legislature and in Congress on bills which affect the profession. Perusal of these records might have a decided effect in the choice of candidates. It is unfortunate that legislation is too often determined by pressure groups. We should realize that concerted action brings results with politicians and we should govern ourselves accordingly.

Respectfully submitted, RALPH P. PEAIRS, M. D., *Councilor of the Fifth District.*

## REPORT OF THE COUNCILOR OF THE SIXTH DISTRICT

Your Councilor for the Sixth District has had an interesting, enjoyable and moderately active year, From the time of the Jersey-Greene Society picnic early last summer to the Postgraduate Conference at Jacksonville, March 30 (just ahead of the deadline) there has been something almost every week or so. Dr. Roy Barnsback of Edwardsville, Madison County, was the only physician in this District to enter the Fifty Year Club this year. The dinner for him March 18 was a nice event. The Pike-Calhoun Society celebrates its Semi-Centennial April 13, after the deadline so all that can be said now is that like other activities of this group it will be good.

Most of the County Societies have been visited. Various organizations have had to listen to your Councilor as seven talks have been made on compulsory health insurance, two professional papers

have been given within the District and two outside, three mental hygiene talks have shown the interest of others in the subject. Council meetings, Postgraduate Conferences in other Districts, Committee meetings of the State Society and affiliated groups add to the time away from home and the practice of medicine. Anyone who says the position of Councilor is a medical politician's job has another think coming. It's a chauffeur's.

If it were not for President Stevenson's doing a lot of the organization and extra-curricular part of the work and for the help of the good friends in the Council, in the Secretary's office and in the County Societies the District as well as the Councilor would be in a bad way. And I get off easy compared to some of the others. By the way, does a Councilor ever live to join the Fifty Year Club?

Respectfully submitted, F. GARM NORBURY, M. D., *Councilor of the Sixth District.*

### REPORT OF THE COUNCILOR OF THE SEVENTH DISTRICT

It is with great pleasure your Councilor of the Seventh District reports all component County Societies functioning well. The number of regular meetings and the attendance has increased somewhat over the past year.

There have been quite a number of relocations and new physicians coming in from other states. Most of the areas which were in desperate need for a physician have been taken care of. This has also increased the membership in this district.

Quite a number of active men in the past, completed their fiftieth year in the practice of medicine and were awarded their Gold Fifty Year Pin and Certificates.

Several special scientific meetings were held in the District this year. One of the outstanding meetings was the Postgraduate Conference held in Taylorville on December 15, 1949. The Christian County Society was host. The attendance was good with an excellent program. The society is to be congratulated on this fine meeting.

The strength of organized medicine is shown by the interest taken by the member of the component societies in their efforts to lead the fight against compulsory health insurance.

The County Advisory Committees to the Illinois Public Aid Commission and any other agencies who have the authority to spend public funds for the assistance in health matters have been quite active, although they do not alaways have the same opinion as those who formulate the orders, they go along and do the difficult duties as well as the pleasant ones.

The Councilor has attended all the meetings of the Council of the Illinois State Medical Society. He has visited most all counties and attended the Postgraduate Conferences in all but two districts.

Your Councilor wishes to express his appreciation to the officers of the component societies for their cooperation during the year, and stresses the need for continued fight against compulsory health insurance.

Respectfully submitted, C. H. HULICK, M. D., *Councilor of the Seventh District.*

### REPORT OF THE COUNCILOR OF THE EIGHTH DISTRICT

1949 was a year of accomplishment in the Eighth District. Lawrence County built their 50 bed hospital and will have it opened by the time of the annual meeting. The ground work has been laid, and bids will be opened next year for Richland County's 100 bed hospital. Added hospital beds will soon be available in Champaign and Douglas Counties.

On the public relations front, one society has formed a "Grievance Committee". All Societies have been active in the education of the public as to the dangers inherent in the government control of doctors, hospitals, and medical care.

More physicians are assuming a role they had formerly left to others, and that is taking part in political activity. This is a healthy sign, and if all members of the profession do their duty regarding voting, and seeing to it that their friends and neighbors vote, Medicine's voice in the community, state, nation's affairs will be larger.

As expected, death has taken its toll of members in the past year; new men have filled most of the breaches, and, although more personnel is needed in some areas, virtually no one need be in need of medical care if he asks for it.

As I see the problem, Medicine's future is going to be determined by the sum total of *individual* Doctors' conduct with the public and the effort they put forth, as individuals, in the coming elections. Failure to support and work for candidates who have the interest of our *entire Republic* and our competitive way of life at heart, can, and will result disastrously for all our citizens and our profession, which is a small but vital part of the American way of life.

Respectfully submitted, HARLAN ENGLISH, M. D., *Councilor of the Eighth District.*

### REPORT OF THE COUNCILOR OF THE NINTH DISTRICT

During the past year as Councilor, I have attended meetings in most of the counties having an organized county society. The meetings have been well attended and interest good.

We have had a goodly number of scientific programs in the Ninth District during the past year:

A Cancer Symposium at Herrin, on May 26, 1949.

A Postgraduate Conference at Mt. Vernon on October 26, 1949. This was one of our best meetings in recent years—an excellent program, good attendance and good interest.

The Southern Illinois Medical Association met in the Ninth District at Eldorado on November 3, 1949. This was one of the best meetings of this society in recent years.

The Six-County Medical Society was enter-

tained several times by Franklin and Williamson County Medical Societies. These meetings were excellent, with good interest and good attendance.

With new hospitals under construction, and some nearing completion at Fairfield, Mt. Vernon, Mt. Carmel, and Metropolis, and building programs under way at Marion and Carmi, the hospital situation will not be so critical in the near future, as it has been for many years past.

Our candidate from this Councilor District for the outstanding General Practitioner of the year went over the top in a great way, capturing both State and National honors. As time passes, we are more than ever convinced this was a wise choice and say again, "congratulations," Dr. Andy.

I wish to thank the officers of the component Societies for their courtesy and co-operation during the past year.

Respectfully submitted, CHARLES O. LANE, M. D., *Councilor of the Ninth District.*

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### REPORT OF THE COUNCILOR OF THE TENTH DISTRICT

Due to conditions over which I had no control, I was unable during the past year to visit the County Societies of the Tenth District as often as in previous years, but it is very gratifying to know that they have been carrying on without my presence, which also proves that none of us are indispensable.

The progress in the building of the three hospitals in this district is going forward, one is finished and serving a grand purpose.

Because of the lateness in holding the Postgraduate Conference in DuQuoin last year, we could not include any mention of it in my last year's report. I must admit there was some bungling in the handling of our program and the attendance was not as large as it should have been for the outstanding essayists who served on the program.

The Postgraduate Conference for the Tenth District will be held this year at the St. Clair County Club, Belleville, Illinois on April 6th and we are looking forward to an excellent meeting. The doctors in this district have several other medical organizations which lend much to our postgraduate conference work. The Southern Illinois Medical Society has a meeting every fall, which is always attended and has excellent speakers; the American Academy of General Practice is planning two Postgraduate Conferences this year besides the monthy meetings held by the Six-County Group which shows that the rural physicians in this district are interested and are taking every advantage in the progress of medical care.

As a reminder, this is an election year. Don't place politics above what is best for yourselves and the public. There has also been a very active educational compaign pertaining to the social welfare state, but that is no sign that you should not do your part to help along and don't forget if the worst should come to pass it cannot be put into operation if the physicians do not sign to participate in this movement.

Respectfully submitted, G. C. OTRICH, M. D., *Councilor of the Tenth District.*

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### REPORT OF THE COUNCILOR OF THE ELEVENTH DISTRICT

It is again a pleasure to report that the medical profession in this district is actively alert to the problems confronting it. This is evidenced by increased membership in the component county societies as well as the increasing number of meetings being held throughout the district.

Your Councilor has continued to take an active part in the Committee work of the Society, and refers you to their reports printed in the handbook. It is difficult for any committee to report all of its activities, especially in the Public Relation and Prepayment Medical Care Plans, and the members of the House must occasionally read between the lines to understand all of the work done.

The Will-Grundy County Medical Society was the host to the annual Postgraduate meeting of the district. An excellent program was presented, and it is too bad that the attendance was not better. Your Councilor wonders if there are not too many medical meetings being held in every locality for any one man to attend all of them. Between state, county, city and regional meetings, the numerous meetings of the Staff of the Hospital or Hospitals with which he may be connected take up much valuable time of the busy general practitioner is occupied. This is a problem that merits serious consideration in my opinion.

No problems of major importance in this district have been brought to the attention of your Councilor. There is in every society the problem of night calls, fees, and changing of physicians. Most societies recognize these problems and are making efforts locally to correct the same. Every component society should be on the alert to correct those things criticized by the public and to inform the public when they are corrected.

Your Councilor wishes to thank the Officers of the Component County Societies for their cooperation the past year. They have fought a good fight so far and we have made excellent progress against our opponents. There is still much work to be done and we must not become complacent and allow our effort to slacken. We must and will win this fight.

Respectfully submitted, E. S. HAMILTON, M.D., *Councilor of the Eleventh District.*

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### REPORTS OF THE COUNCILORS AT LARGE

My term as Councilor-at-Large expires with this Annual Meeting of the Illinois State Medical Society. It culminates too a rather unusual and protracted term of five years as "Acting President" in 1944, President-Elect in 1945 and 1946, President in 1947, and Councilor-at-Large from 1947 to 1950. For all of these high honors, and for the privilege

of having been allowed through so many years to serve my friends in the medical profession of the State of Illinois, I am profoundly grateful. Whatever sacrifices of time and energy these years may have exacted, they dwarf into insignificance compared with the satisfaction and warmth and joy which have come to me in return through my association with my confreres.

During this past and last year as Councilor-at-Large, I have been able to attend most of the meetings of the Council and have profited from these meetings vastly more than I contributed.

It gives me pleasure and satisfaction to remember, that even though my activities in and for the State Society are culminated, I have two more years of an unexpired term to serve as a Trustee of the Board of Education for the City of Chicago. I rather feel that I do not need to tell my friends, the doctors of Illinois, and particularly of Chicago, that I shall guard their vast and varied interests, as well as those of the school children of Chicago to the best of my ability!

And so in this, my closing report, I say to the House of Delegates, "Vale," and thank you all very much!

Respectfully submitted, ROBERT S. BERGHOFF, M.D., *Councilor-at-Large.*

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This year ends my Twenty-fifth year as a member of the Council of the Illinois State Medical Society of this House of Delegates. During this quarter of a century many changes in the personnel of the Council have occurred. Only one other member of the 1925 Council remains—our efficient Secretary, Dr. Harold M. Camp. This period has witnessed a tremendous increase in the activities of the Society as well as being a period of the greatest scientific achievement in medical history. In retrospect, someone has very aptly said, "Each generation and some pundit thereof has undoubtedly considered his segment of history as the most important." It would be consistent, therefore, to say that we are all entering a unique phase in the evolution of our culture. Advancing through the stone and iron to the machine age, we now stand on the threshold of the atomic or ultra atomic era.

Of considerable concern to all has been, and is, the adjustment of our social institutions to the demands created by the machine age. Not long ago, G. A. Chesterton, a noted New York Times Magazine columnist, stated in a thesis that there should be a moratorium on the advances and discoveries of science so that the social institutions could catch up in their evolution with the machinistic improvements. Whatever one's sympathy may be in regard to this, it appears self evident that the world in general is heaving under the impact of various "isms" called forth by a variety protagonist. Basically, the conflict is one of supremacy of the State in which the rights of individuals are submerged and the way of life in which the rights of individuals are safeguarded and the individual in a true sense is a citizen. This has been well termed, "The American Way of Life."

Of some concern to the so-called Western World is the philosophical concept of socialism euphemistically termed, in some quarters as planned economy. Its particular application may vary in detail, but the general concept remains unvaried and should be understood. How seriously it touches the basic morale of the average American can be attested by a cross section of the opinion in any hospital Medical Staff Room. During this past quarter of a century, we have seen planned economy or socialism rapidly gaining ground and our American way of life and free enterprise being pushed in the background.

Under socialism the State owns and operates the principal means of production and distribution of wealth. This ownership would extend to all lands, mines and factories, to all machinery and all materials, transportation and public utility. Under this system personal liberty is obliterated. Assignment of work is a necessary corollary and this negates freedom of choice and competition. As a result the natural incentives to labor and work are destroyed.

Certainly, ours is a precious heritage. To be an American, to salute the flag and the liberty for which it stands has been part and parcel of our national pride and patriotism. America has been, and still is, indeed, the land of promise and an oasis of liberty in a miserable world. To be more specific, the small cloud first seen on the medical horizon in the early part of this quarter century in the form of the Sheppard-Towner Bill has gradually gained in dangerous momentum until at present the entire horizon has become obscured. The free enterprise system which has made America great and the medical profession the envy of the world is threatened by socialization and regimentation by the bureaucrats and Fair Dealers of the Freedom is being sacrificed for promised security from the "cradle to the grave."

The activities of your Councilor-at-Large during the past year have been directed toward activities on special committee at the state and local levels; many conferences, lay and professional; attending the AMA House of Delegates (unofficial) and with patients, civic clubs, hospital staffs, farm bureaus, and many organizations urging them to carefully consider the trends and warning them that if American medicine can be taken over by the Federal bureaucracy, it will be only a matter of time until education will be taken over, then insurance, the press and the public intelligence, finally, all entertainment and social expressions.

We still have a job to do. Organized medicine under the AMA program is now on the offensive. American medicine all through America should ponder well the words of Daniel Webster uttered in his eulogy on George Washington in 1932: "But who shall reconstruct the fabrics of demolished government? Who shall raise again the well proportioned columns of constitutional liberty? Who

shall frame together the skillful architecture which unites national sovereignty with state rights, individual security and public property? No, if these columns fall, they will be raised not again."
Respectfully submitted, I. H. NEECE, M. D., *Councilor-at-Large.*

## REPORT OF THE EDITORS

The *Illinois Medical Journal* is the official publication of the Illinois State Medical Society, and is actually owned by the membership as a whole. The Council, under the By-Laws, is responsible for its publication and directs its activities. The Journal Committee and the Editorial Board, both of which are selected by the Council, held joint meetings to give serious consideration to the many problems which are constantly arising. It is the desire of these groups, as well as of the Editors, to publish in the *Journal* the type of material that will be of greatest interest to the membership as a whole. We have been most fortunate in receiving many fine original articles for publication, as well as interesting case reports so that a stock pile has been available at all times during the past year.

It is unfortunate that we have been unable to publish all articles which have been received. It has been our policy to refer many of the papers to members of the Editorial Board to get their final approval before publication. This is in keeping with instructions we have received from the Council. We have endeavored to get two case reports in each issue, and these have been quite popular, according to reports which have been received.

Unfortunately many papers are too long, as they contain historical and bibliographical material, which is available elsewhere to most of our readers. Frequently papers are returned to the writers, and sent back much shorter, and we believe increasing the general interest and usefulness through this procedure. It is our desire to publish as many papers as possible in each issue of the *Journal,* and when short papers are presented, more of them can appear in the average issue.

For many years it has been necessary that the complete transactions of the House of Delegates be published in the July issue and more recently we have published the first session of the House in the July issue and the second meeting in the following number. We would like to know whether or not the House of Delegates would prefer to have these minutes abstracted, so that they may be presented without losing any of the factual data, yet minimizing space which could be used for scientific articles. The recommendations of this House of Delegates will be referred automatically to the Council for final action, and it seems quite probable that the Council will follow the recommendations of the House.

During the past year it has been the policy of your Editors to get together at least one day each week in our Chicago office, to go over many articles, case reports, prepare short abstracts from current medical literature, and to carry on the many other duties which are constantly before us. We receive more material for publication than we could possibly use even though the *Journal* was issued two or three times each month, instead of monthly, as it appears now.

Several new features were considered during the past year by the Editorial Board and the Journal Committee. We have recently started publishing regularly case histories from Cook County Hospital, under the co-editorship of Drs. Karl Meyer and Leo Zimmerman. These cases have been selected as the most interesting and instructive from that institution. The presentation follows the general plan of the Clinicopathological case records of Massachusetts General Hospital except that the material stresses the clinical rather than the pathological aspects.

The Editorial Board and the Journal Committee last summer met with the Editors to select the outstanding papers published during the fiscal 1948-49 year, for the awards granted by the Council. After much discussion, Dr. Archibald L. Hoyne of Chicago was awarded the Class A prize, for the best paper from a literary standpoint. The article, "Intrathecal Therapy Contraindicated For Meningitis," was published in the November, 1948 issue of the *Journal.* An article presented by Drs. Paul L. Bedinger and Louis R. Limarzi, Chicago, was judged the most outstanding original work, and the authors received the class B award. This paper, "The Clinical Interpretation of Sternal Puncture," was published in the December, 1948 *Illinois Medical Journal.*

During the past year, no changes have been made in the general appearance of the Journal, although changes have been made in the various headings throughout recent issues. The January, 1950 *Journal* cover, had a picture of Andy Hall, the outstanding general practitioner of the Nation receiving the medal from the President of the American Medical Association. This seemed quite appropriate especially because Dr. Hall has been an active worker in this Society for so many years, and served some 22 years as a member of the Council. Likewise, the President of the American Medical Association, Ernest E. Irons, has been quite active as a member of our Society for more than 45 years.

We have endeavored to increase the number of scientific editorials during the past year, and several have been submitted by guests selected to present them on present day timely subjects. However, preference has been given to present editorials on the current fight against compulsory health insurance and the Society's participation in the National Education Campaign. We hope that in the near future proposals to place all matters concerning medical care in the hands of the Government will be forever forsaken, and that we will again be able to devote more time and energy to medical science and the care of the sick.

The "News of the State" section in the *Illinois Medical Journal* has been more popular than ever, and we are constantly receiving notices for this department. We have failed to find any other state society journal carrying as much news of the state, referring to activities of component societies and individual members.

Your Editors once more desire to thank the Editorial Board and the Journal Committee for their assistance and encouragement. Furthermore, members of these committees deserve a vote of thanks for their devotion and work in the Society. It has indeed been a pleasure

to work with them. We likewise again pay our respects to Mr. L. E. Malley, who as business manager has worked diligently caring for the many details in his official duties. He has been careful in the selection of new advertising contracts and invariably is in touch with the American Medical Association, and leaves the decision as to the acceptability to the members of the Journal Committee.

As we have previously stated, this is your *Journal,* and those who are directly responsible for its publication are always anxious to receive your criticisms and recommendations, as members of the House of Delegates. Your suggestions will receive prompt and serious consideration.

Respectfully submitted, HAROLD M. CAMP, M.D., THEODORE R. VAN DELLEN, M.D., *Editors.*

## REPORTS OF STANDING COMMITTEES

### REPORT OF THE COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

The Committee on Medical Service and Public Relations has held four meetings in the year since our last report. With the aid of the chairman and the secretary of the Society acting as executives, these meetings sufficed to supervise the work of the committee's staff, which falls into two main divisions: our interest in legislative affairs, in charge of Mr. John W. Neal, general counsel; and the Illinois phase of the National Education Campaign of the American Medical Association, in charge of Mr. James C. Leary, director of public relations. Both are complex operations, difficult of detailed explanation. In summary, however, we might say that both are going well and that the Illinois State Medical Society is carrying its full share of responsibility and winning its full measure of support. It has been an extremely busy year, filled with intense activity.

LEGISLATIVE—The study of pending and proposed health legislation, local, state and national, continues to be of the greatest importance in the committee's work.

With respect to health legislation in Congress, the committee is able to keep posted on current and possible future health and welfare legislation through the Social Legislation Information Service and through the numerous bulletins and other releases of the Washington office of the American Medical Association's Council on Medical Service. Frequent requests for action are rereceived from the Washington office, and are carried out by the committee. Copies are secured, and retained for reference, of the testimony of the numerous witnesses appearing before Congressional committees for and against the many pending health and welfare measures.

At the state level, the 1948-1949 session of the Illinois General Assembly received well over one hundred bills directly or indirectly related to health and medical care. All of these were carefully digested and studied by the committee. All bills considered sound and desirable were actively supported, while several very bad bills were vigorously opposed. Still other health bills which were essentially non-controversial were closely followed, so that any substantial amending of them could be dealt with properly. From the standpoint of this Society, the 1948-1949 state legislative session was by any standard a most satisfactory one. A $6,000,000 state-aid for tuberculosis control and eradication program was enacted, after having failed at two previous sessions. Two determined assaults upon the standards and quality of medical care in Illinois were successfully repulsed. Only the loss of the "dog-pound" bill which was approved but not sponsored by the society, to an hysterical and heavily financed anti-vivisectionist lobby prevented the session from being a complete success. Constant vigilance in the halls of the state is a costly and time consuming effort for the Society, but an ever-increasing number of our law makers seem to recognize that it constitutes the discharge of an important public responsibility. Your chairman and officers of the society appeared several times as witnesses before legislative committee hearings in Springfield.

PUBLIC RELATIONS—The Illinois State Medical Society was probably the first such organization to undertake to improve the relationship of the medical profession to the public. By 1945, however, the determination behind the drive for socialization of medicine made it obvious that such greater effort was needed, and the Bureau of Public Relations was set up in 1946 to act for the Society in presenting our side of the story to the public.

Speakers' Bureau. The main reliance of this campaign of education has been and is on a direct personal approach to every possible individual by physicians carrying the message of the menace of compulsory government sickness insurance, with resultant political control of medicine. It was necessary to recruit, indoctrinate and make available a large number of speakers. Such a procedure uses to its full potential the principal advantage in the hands of the medical profession—the confidence and trust of the individual patient in the personal integrity and dependability of the individual doctor. Semantically, it is perhaps impossible to persuade the public that big impersonal "organized" medicine, or medicine in the abstract, is anything but the bugbear our enemies have called it. But when the problem is reduced to the simplest human elements, the doctor wins. Our speakers' bureau has accomplished that task set for it.

The speakers' bureau has a total of 320 speakers listed. Actually a substantial part of these are not active for various reasons.

In the past year up to April 1 the bureau has assigned them to 435 audiences. It is impossible to arrive at any satisfactory estimate of the number of persons reached in Illinois by all our speakers but it will certainly run close to 100,000 in individual units ranging from 25 to 750. Some speakers have taken as many as 25 assignments, some as few as one.

The speakers' cards devised last year to make the facts on the subject of socialized medicine quickly available to our speakers, have developed into Illinois' major contribution to the National Education Campaign. These cards, pocket-sized and mimeographed, are strong enough to stand considerable handling. They contain sufficiently detailed abstracts of S. 1679 to enable a speaker to discuss the bill intelligently, together

with summaries of and answers to many of the arguments advanced by our adversaries. A record is kept of all those holding sets of these cards, and new or substitute cards are sent to them as necessary, after the fashion of a loose-leaf encyclopedia.

Twenty-eight states are now using them. The original printing of 200, which had arisen to 700 at our last report has now grown to 1,250, of which only about 350 are in Illinois. These cards are supplied free to our own speakers, of course, and on a sample basis to others, but a charge of $1.00 a set is made to those states desiring large quantities. Some of the states using them and the number in use, are as follows: New York, 1,500 (reproduced by that state); California, 196; Iowa, 144; Hawaii, 13; Oklahoma, 157; Oregon, 100; Georgia, 16; Florida, 15; Pennsylvania, 50.

In addition, various officials of the American Medical Association and of Whitaker & Baxter have these cards for source material reference. Outside of medical circles and our own speakers, many sets of cards have gone to our allies within the Chicago and Illinois State Dental Societies, to officers of various insurance groups and to certain business leaders who do considerable public speaking on our side.

A continuing effort stemming from the speakers' bureau is that directed toward the stimulation of interest and activity among our component societies and the woman's auxiliaries, both at state and county levels.

The work of the speakers' bureau has also brought Mr. Leary into contact with numerous other groups interested in fighting socialism, especially the Chicago and Illinois State Dental Societies and some of the large number of organizations of insurance men. The dental groups have been particularly cooperative and have made much use of our material about programs and are now well on the way toward setting up an effective program, both on their own and in collaboration with our group. Mr. Leary in February addressed a breakfast meeting of representatives of the Illinois State Dental Society from all parts of Illinois.

Another major effort of the speakers' bureau was the Second Speakers' Training Conference held September 11, 1949, in Chicago. The attendance was 207, including representation from most of the larger downstate counties, the Woman's Auxiliary, state medical societies of Wisconsin, Iowa, Indiana, Michigan and Tennessee, from the American Medical Association and from Whitaker & Baxter. It was planned (1) to stimulate our membership's interest in the Campaign by pointing out to them the serious situation confronting medicine, (2) to encourage them in their efforts by showing how much public support is being won for the fight, and (3) to give them some idea of the importance of proper presentation and how to do it. The meeting was highly praised in concept and execution by all who attended. Several other states immediately started to organize meetings similarly set up. It was so successful in achieving its purposes that your committee is considering the possibility of holding another, probably next fall.

Pamphlet Distribution. The second major method of direct personal approach taken by the Bureau of Public Relations to carry out the Illinois phase of the National Education program is the distribution of pamphlets.

In this respect, Illinois ranks well up in the list of states, according to data compiled by Whitaker & Baxter, which is the source of most of the literature now being distributed. A brief resume of their most recent report as of January 20, 1950, will give the picture.

More than 50,000,000 pieces of literature have been distributed nationally. Illinois has taken about one-sixteenth, or 3,180,700. That is higher than the proportion of Illinois' population to the national figure. The Illinois State Medical Society is credited with 3 per cent of this total or approximately 95,000. This total has been variously distributed, but no suitable records are available. It is the practice of the speakers' bureau to ask whether literature may be passed out at meetings to which our speakers go and, if acceptable, to send a sufficient supply of pamphlets to give one to every one in the audience. When only a few are involved, these are taken from a stack kept in the office. If a large number are required, they are shipped direct from Whitaker & Baxter. Many thousands have been so distributed.

In addition, the speakers' bureau has purchased and distributed pamphlets from other sources and has also continued to send out our own pamphlets on rural medical care and voluntary prepayment insurance. Altogether these would add another 25,000 items to our distribution total.

The Woman's Auxiliary has been extremely helpful in this work. Aside from pamphlets distributed at various meetings organized by auxiliaries, special mention should be made of two activities. The Sangamon County Auxiliary, which has adopted the practice of setting up booths at the State Fair and at the many state conventions held in Springfield, staffed by Auxiliary volunteers, and has been successful in carrying the message to many thousands of persons. And the Chicago Medical Society Auxiliary worked out a system for staffing a booth and distributing literature at a very large national insurance meeting in Chicago, in which Whitaker & Baxter were deeply interested.

Pamphlets are a satisfying method of reaching a large segment of the public. Many of our members have cooperated effectively in this activity, but the number should be much larger. It is simple to keep a supply of these pamphlets on hand in one's reception room where patients pick them up and take them home. Some men, in fact, have removed other reading material from their reception rooms, and move many hundreds of pamphlets into the hands of the public. Others keep an additional supply on their desks and devote a minute or two with each patient to comment on the dangers of socialized medicine and to the suggestion that the patient read some of the literature. Such an effort is not embarrassing in any way. It is a duty each of us

should undertake. Pamphlets in any quantity desired may be had on request through the speakers' bureau.

Resolutions and Letters. Once persuaded that government medicine is wrong, the voter individually is asked to write to his senators and congressman and express his conviction, or, in a group, to adopt a resolution condemning socialized medicine and send it to Washington. These two actions are one of the objectives of our campaign as our best weapons in Washington, and at the same time a measure of its effectiveness. It is impossible to estimate how many letters have gone to Washington, though from congressmen's remarks we know there have been many thousands. However, we can get some idea of the number of resolutions, since each group is asked to send us a copy. These in turn are forwarded to Whitaker & Baxter to be combined with those from other states into an overwhelming protest against Socialism.

A recent compilation (March 15) by Whitaker & Baxter shows that Illinois had produced written and signed copies of resolutions adopted by 307 organizations in all. That total is substantially higher now, probably about 350. Only Indiana with 493, and Ohio, with 386, stood above Illinois in the Whitaker & Baxter list of states. The compilation showed a national total March 15 of 4,181. These are resolutions of which we have a signed copy in hand. We know also that many organizations have adopted and sent resolutions to Washington, without forwarding a copy to us, but there is no way to estimate the number satisfactorily.

The speakers' bureau has enjoyed the cooperation of Whitaker & Baxter in building up the resolution total. In fact, a method of obtaining local unit resolutions from groups like the American Legion which have endorsed us nationally was tried out and perfected in Illinois.

Illinois' resolution total should be much higher. Every speaker should try for a resolution from every group he addresses and, where such an attempt was not made originally, should go back to the officers and ask for one now. The need for written resolutions is another reason for reporting all speeches to the speakers' bureau.

The committee desires to call this phase of the National Education Campaign to the special attention of every member of this Society with a request for action. It should also be pointed out that there is still a large number of county medical societies and some auxiliaries which have not yet adopted a resolution and sent in a signed copy, difficult as it may be to believe it. That situation should be corrected immediately.

Summarizing this phase of the work, your Committee on Medical Service and Public Relations submits to the House of Delegates the belief that the work of the speakers' bureau in carrying out the Illinois phase of the National Education Campaign, one of the most essential activities of the society, is being handled satisfactorily. Illinois stands well up in the roster of states in the matter of achievement, as we have shown, and many of its ideas, such as its speakers' cards, have brought our society national recognition.

The work may seem expensive, but no matter what it costs, certainly no one will argue that it is not of great importance, unless we are to submit tamely to enslavement. Moreover, figures collected by the American Medical Association indicate that Illinois' per capita investment, matched against that of other states, is low—$3.07 for 1949, as compared with an average of $7.31 for 32 states reporting. For the eight largest states listed, the per capita public relations cost was $6.99 and for the 23 smaller states it was $8.19. The range of per capita figures goes as high as $44.44 for Hawaii, with New York at $3.50, Pennsylvania at $4.57, California at $15.20, Ohio at $4.50, Wisconsin at $5.96, among the larger states. Even if some of the activities of other committees are added to the Illinois public relations total, our figure would still be low, in comparison.

We mention these statistics for two reasons. One is to assure our membership, whose funds are being expended, that we are getting full value for our money. Another is to note that it may be necessary to increase our expenditures to take on activities so far not included in our program, in an attempt to beat Socialism once and for all. We have managed by agility and resourcefulness to keep well to the fore on a minimum expenditure, as compared with other states, but a supreme effort in other and new arenas may involve additional costs, and our society should be prepared for it.

Other Activities. The speakers' bureau and the National Education Campaign have properly absorbed most of our energies in the last year, but we have not lost sight of our other activities.

Press and Radio. Friendly contact with press and radio have been maintained and improved throughout the year. A total of 20 press releases was sent out in the name of the society, of which five had to do with some phase of socialized medicine. All were well received and won wide reproduction by both media.

Rural Medical Care. One press release concerned the medical students supported by loans from the joint Student Loan Fund maintained by the society in cooperation with the Illinois Agricultural Association. This was widely printed throughout the State. Our public relations counsel also worked with the Associated Press in developing a feature story on the improvement in rural medical care in Illinois for national distribution.

Dr. Andy Hall. The selection of Dr. Andy Hall of Mt. Vernon, first as state and then by the American Medical Association as national outstanding general practitioner was of course the major public relations event of the year. It brought and still brings Illinois wide publicity.

Actually only one news story on Dr. Hall was issued at the time of his selection by the Society. This made every paper in the state. Material was then collected for presentation to the trustees of the American Medical Association. The facts were organized into a 23-page statement, which was supported by dozens of letters from friends, patients and associates, and pictures dating back as far as the Spanish-American War. These were all bound in separate cellophane envelopes, which in turn went into a large loose-leaf binder, which was forwarded to the Board of Trustees, with appropriate letters from Dr. Camp and the Council. Added to this

material was a brief summary which presented vividly to the trustees our reasons for urging Dr. Hall's selection. This technique of presentation was highly commended by the trustees to Dr. Hamilton.

Meanwhile, the biographical material was put on stencils which were taken to Washington. However, when it became obvious that Dr. Hall had a good chance to win, they were mimeographed, so that, when the selection came through, every press, radio and television reporter and cameraman covering the meeting was immediately supplied with a copy. This so simplified their work that Illinois won wide commendation from A. M. A. executives and the press generally, with resultant goodwill and general satisfaction. With previous selections, the press had encountered difficulty in immediately obtaining essential facts concerning the man chosen.

The second factor in the happy outcome was Dr. Hall's presence at the home of his son near Washington. Dr. Harold M. Camp, the secretary, had learned of this and he summoned Dr. Hall to the meeting as soon as the choice was announced. Thus Dr. Hall was immediately put through the wringer of press, radio and television interviews, while the announcement was fresh spot news, with tremendous publicity resulting.

Altogether the whole event went off as planned. The press and radio interest in Dr. Hall still continues on a spontaneous basis. Hundreds of news stories have been written on him and he has appeared on many radio and television programs. His fame has reached the magazine stage now and there is even a possibility that a book will be written on his remarkable career. Mr. Leary devotes considerable time to this activity.

Tuberculosis. Our public relations and legislative representatives continue to work with the tuberculosis control committees of the Chicago and Illinois State Medical Societies to bring about anti-tuberculosis work in Illinois.

It might also interest the House of Delegates to know that Mr. Leary has been appointed a member of a committee of the National Association of Science Writers, of which he is a former president, to work out a code of press relations with a committee of the American Medical Association, headed by Dr. Austin Smith and including your chairman as a member.

POLITICAL ACTIVITY—One more topic remains for discussion—political activity on the part of physicians. Medical societies, as corporations, are barred by law from contributing funds or services to any candidate for the Congress or the Legislature. However, individual medical men are free and, in fact, duty-bound as citizens, to take a proper interest in elections. Political action committees have been organized throughout the state by individual members of the medical, dental and pharmaceutical professions, which are actively and aggressively at work. This is a highly commendable activity, barred to medical societies as such, but it is hoped that individual members, as citizens, will cooperate to the fullest extent in establishing and maintaining them. The reason why we are faced with the continuous threat of socialization is because we have sent, or acquiesced in sending, men to Congress who favor socialized medicine. Now, while employment is at a high level and people are more or less content with a capitalistic system, is the time to get into the fight and send men to Congress who will stand firm against Socialism.

This committee submits therefore the earnest recommendation that the House of Delegates formally urge every member to become active himself and to join others in his community, who think as he does, in helping send such men to Congress. Every physician should be registered and see that all his family and friends are registered and properly indoctrinated. And he should give willingly of his money, time and influence in support of the right candidates. This is not a partisan movement. It is an anti-Socialism movement. Our nation is predominantly sound, but the voters need urging. Let us help urge them.

In conclusion: This is a long report. But it has still touched only the high spots of a year of most intense activity in our public relations program and in Springfield. Long as it seems, we have only indicated the general lines of our efforts, and omitted much detail, in the interests both of brevity and circumspection. The fight against Socialization is essential if we are to survive as a free profession and we have therefore not hesitated to inflict on the House of Delegates what may seem to be a formidable document. At the same time our efforts in Springfield are of utmost value to the welfare of the people of Illinois. Despite its length, therefore, we urge a careful study of this report by every delegate. No activity of the Society is more important than the National Education Campaign and we desire the fullest understanding and cooperation from every member. If we lose, we will never have another chance, but we can lose only by failure to put all our effort and resources into the battle at the right time—which is now.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman,* EDWIN S. HAMILTON, M. D., EVERETT P. COLEMAN, M. D., WALTER STEVENSON, M, D., *President—ex-officio,* HAROLD M. CAMP, M. D., *Secretary—ex-officio. Committee on Medical Service and Public Relations.*

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### REPORT OF THE MEDICO-LEGAL COMMITTEE

The increased activities of this Committee the past year seems to indicate that it still serves a very useful purpose. Numerous calls have come to every member and as heretofore the major portion of these have to do with fractures or burns.

With the vast increase of industrial and highway accidents, it becomes increasingly important for every medical man to be alert to every incident that could lead to a malpractice suit, and to use every effort and precaution to avert such a possibility. As everyone knows, the majority of these cases are purely for blackmail purposes, but these too need proper attention and one can avoid much grief and worry by having good medico-legal protection.

The Committee is always ready to provide any and every service requested by our members.

Respectfully submitted, *Medico-Legal Committee,* OSCAR HAWKINSON, M. D., *Chairman,* E. E. BIHSS, M. D., PLINY R. BLODGETT, M. D., RALPH McREYNOLDS, M. D., A. L. NICKERSON, M. D., DARWIN POND, M. D.

### REPORT OF THE COMMITTEE ON ARCHIVES

Your permanent Committee on Archives begs leave to report as follows:

Preparation of the second volume of the History of the Illinois State Medical Society required many meetings during the year 1948-1949. This year there has been need for fewer meetings. These have been held in Chicago where the actual production of the book is taking place.

Sifting of the archives now in possession of the Society is a laborious task. There is, however, need for additional data which can be supplied only by component county societies. Miss Ella Salmonsen, 6732 Newgard Avenue, Chicago 26, Illinois, is engaged in compiling this information. The committee urges county society secretaries to forward to Dr. Harold M. Camp, Secretary, biographies of members, minutes of meetings, old letters, newspaper comments and other material of historical nature. Other volumes of the history of our society may be desired at some later date. Our archives must grow if we are to have a worth-while source of material.

Respectfully submitted, D. D. MONROE, M. D., *Chairman,* E. H. WELD, M. D., J. J. MOORE, M. D., *Secretary,* DAVID J. DAVIS, M. D., *Permanent Historian. Ex Officio.*

### REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The Committee has met several times during the year and has considered various matters referred to it by the Council. Our report for 1950 will follow the same general plan as the report for 1949.

THE GENERAL HOSPITAL SITUATION—In our Report for 1949, we summarized the growth of hospitals in this country from 1900 to 1947. Since this report was made, there has been some increase in the number of hospitals throughout the country, but there is still some shortage of beds. The situation is not as acute as it was two or three years ago, but expansion is urgently needed by many hospitals. The cost of construction continues to be a deterrent, although building costs have dropped slightly. There does not appear to be much prospect of a marked reduction in cost for several years. Some hospital construction was carried out in Illinois under Public Law 725, which is summarized up to January 27, 1950 in the following table:

HOSPITAL CONSTRUCTION IN ILLINOIS UNDER PUBLIC LAW 725
(THE HOSPITAL SURVEY AND CONSTRUCTION ACT)
PROGRESS REPORT—FROM START OF PROGRAM TO JANUARY 27, 1950

| *Name and Location of Hospital* | *Normal Bed Capacity* | *Project Cost* | *Percentage Construction Completed* |
|---|---|---|---|
| MOUNT VERNON: Good Samaritan | 117 | $2,100,000 | 38% |
| ANNA: Anna City | 54 | 1,161,976 | 67% |
| MOUNT VERNON: Mt. Vernon State T. B. | 100 | 2,117,267 | 62% |
| FAIRFIELD: Fairfield Memorial | 84 | 1,236,174 | 80% |
| LAWRENCEVILLE: Lawrence Co. Memorial | 46 | 966,565 | 90% |
| FLORA: Clay County | 50 | 904,061 | 99% |
| ALEDO: Mercer County | 55 | 787,682 | 100% |
| CARTHAGE: Memorial | 46 | 732,569 | 38% |
| RED BUD: St. Clement's | 61 | 1,099,482 | 100% |
| MT. CARMEL: Wabash County | 51 | 924,000 | 23% |
| CHICAGO: Provident | 32 | 527,000 | 10% |
| CAIRO: St. Mary's Nurses' Home | 41 | 402,776 | 100% |
| St. Mary's Hospital | 65 | 1,193,000 | Bid opening: May, 1950 |
| CARMI: Carmi Township | 50 | 875,000 | Bid opening: April 1950 |
| CARLINVILLE: Carlinville Hospital | 50 | 875,800 | Bid opening: April 1950 |
| JACKSONVILLE: Passavant Memorial | 140 | 2,100,000 | Bid opening: April 1950 |
| EFFINGHAM: St. Anthony Memorial Includes Nurses' Home of 39 Beds | 150 | 2,792,200 | Bid opening: Summer 1950 |
| OLNEY: Richland County | 100 | 1,800,000 | Bid opening: 1951 |

| | | | | |
|---|---|---|---|---|
| LINCOLN: | Abraham Lincoln Memorial ..... | 100 | 1,700,000 | Bid opening: 1951 |
| CHICAGO: | District Health Center ..... | | 3,000 | Contracts to be let in 30 days |
| TOTAL: | General Beds ..... | 1,213 | $24,298,552 | |
| | T. B. Beds ..... | 100 | | |
| | Beds in Nurses' Homes ..... | 80 | | |

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Division of Hospital Construction Services

THE COST OF HOSPITALIZATION—The cost of hospitalization continued to rise a little during 1949. At the beginning of 1950 the cost per patient per day varied from $17.00 to $22.50 in this area of the country. This increase in cost occurred in spite of the fact that hospitals continued to pay relatively low salaries. There is a definite improvement in the quality of nursing care, particularly in some hospitals. However, the nursing shortage continues to be acute throughout the country. Some schools of nursing education have been able to fill their quotas by making their programs more attractive with better training, scholarships, and better living quarters.

Too many hospitals still have the impression that they do not need to serve the public, and in many instances patients and their friends have been subjected to very discourteous treatment. The hospitals have been so busy trying to find beds in which to put patients that in many instances they have forgotten that their main reason for existence is to serve the public.

A SPECIAL HOSPITAL PROBLEM—During the year one of the county medical societies made the following complaints to the Council concerning one of the hospitals in the state:

"1. Rudeness and cavalier treatment on the part of the entire staff when a local physician endeavors to refer a patient for either in- or out-patient treatment.

2. Failure of the hospital to call patients in for and one can avoid much grief and worry by having admission after promising them admission following out-patient visits.

3. Failure to return x-ray films—property of referring hospital or physician.

4. Failure to send the referring physician an abstract of the case, giving findings, procedures carried out, and recommendations for future therapy."

The Council referred these complaints to the Committee on Medical Education and Hospitals, and the Committee, in turn, promptly referred them to the head of the institution involved. He investigated the situation thoroughly, and promptly took steps to correct it.

These complaints illustrate the great importance of what has been said before; viz., the need for greater service to the public and the profession by the hospitals and all of their personnel.

THE ROLE OF THE HOSPITAL IN MEDICAL EDUCATION—The hospital is playing a more and more important role in medical practice and in medical education. The investigation of many problems in medicine requires careful study in the hospital. The management of hospitals has been placed largely in non-medical hands. As a result, hospital management and hospital staffs have tended to drift apart. There is a strong feeling in some influential quarters that doctors are poor business men, and that they should have very little to say about the running of hospitals, and should not serve on their Boards of Trustees. There has been a tedency in some hospitals for lay personnel to push the staff around, and tell them how to practice medicine. The only way in which a hospital can be properly run is by intelligent cooperation between management and the staff, and it is diffcult to see how the staff can play a major role in the development of a hospital without representation on the Board of Trustees.

Hospitals must assume the major responsibility for the education of their staffs, and of their interns and residents. Most of them now conduct regular scientific meetings and clinico-pathologic conferences. Most of them could arrange more intensive programs for the training of their interns and residents. Hospitals should encourage all members of their staffs, including interns and residents, to attend as many scientific meetings as possible outside the hospital so that they will be constantly exposed to recent developments in medicine. Our knowledge is developing so rapidly that physicians can keep up to date only by constant study.

In the Chicago area as many hospitals as possible should develop teaching arrangements with one of the medical schools. There are five approved medical schools in Chicago, and these schools owe it to the public and to the profession to expand their sphere of influence as much as possible. At least two hospitals are now contemplating affiliation with one of the schools. It is hoped that as many as possible will make a serious effort to work out cooperative arrangements. Hospitals do not need to lose their identity by affiliations with the medical schools. In fact, such an affiliation greatly strengthens the hospital and assures its future. The Chicago Medical School, which was approved only a short time ago, is greatly in need of additional hospital facilities. Affiliation with this school would be a great forward step for some of the Chicago hospitals, and would be valuable for the school and for medical education in general.

The College of Medicine of the University of Illinois is developing rapidly, and is expanding greatly its facilities for the care of charity patients. However, it has one very serious lack; namely, a hospital for the care of the private patients of its staff. At the present

time, the members of the clinical staff must take their private patients to hospitals all over the City of Chicago. These hospitals, in many instances, are separated from the medical school by great distances. A great deal of time could be saved if the faculty of the medical school could see their private patients and do their teaching and research in one geographic area. It is the hope of the Committee that the Illinois State Medical Society will see its way clear to support the development of such a hospital. There has been a feeling in some quarters that State funds should not be used for such an institution because it would compete with the private practice of doctors not connected with the medical school. Instead of providing competition, a hospital of this type would render a great service to all of the physicians in the State. They would be able to refer their difficult problems to such a hospital for careful study and recommendations concerning treatment. No medical school can render its greatest service unless it has facilities for the study of both charity and private patients. There are only a few full-time men in the clinical staff at the University of Illinois Medical School, and the University has no intention of starting a pay-clinic. Most members of the clinical staff receive no salary from the medical school, and must make their living entirely by private practice. Many other state schools already have facilities for the care of private patients, including the University of Michigan, the University of Wisconsin, the University of Iowa, the University of Minnesota, Ohio State University, and the University of California.

THE GENERAL PRACTITIONER—The problems of the general practitioner are gradually beginning to receive the attention that they deserve. The American Academy of General Practice, although established only recently, already has 12,000 members, with a chapter in every state. The first issue of their new Journal, GP, appeared only about a month ago. The future of this journal seems assured with Dr. Walter Alvarez as the editor. The American Academy of General Practice, like the American College of Physicians, and the American College of Surgeons, has a very important role to play in the development of American medicine. It is sincerely hoped that any bitterness which has arisen will disappear. The specialist needs the general practitioner; and the general practitioner needs the specialist. Both groups should approach the solution of the problems of medical practice in a spirit of cooperation. As many hospitals as possible should establish departments of general practice, and as many medical schools as possible should develop training programs for the general practitioner. The Specialty Boards should make it possible for general practitioners to specialize by giving some credit for work in general practice. As a matter of fact, a few years of general practice may provide an excellent background for a specialty, because it makes the doctor acutely aware of the various manifestations of disease and of the problems of the patient as an individual.

GROUP PRACTICE—There is still some opposition on the part of the profession to the development of clinics, but they are developing at a rapid rate. They provide an excellent opportunity for physicians to devote their attention to a special field of medicine, and by a cooperative arrangement to render a high quality of medical care. A clinic in a small town can render specialized medical service to a large surrounding rural area. However, provision must always be made for patients to receive care in their homes when they need it. When patients are sick, they must be taken care of, regardless of where it is necessary to render the service.

THE NURSING PROBLEM—There is still a serious nursing shortage, although it is not as acute as it was. The most important reason for the shortage continues to be economic. Nurses are still underpaid, and no adequate provision has been made for rewarding long years of faithful service. Good nursing care is extremely important, and the medical profession should do everything in its power to raise the standards of the nursing profession. Without good nurses, good medical care is impossible.

A great deal of discussion has recently been created by the Brown Report, published by the Russell Sage Foundation. According to the Brown Report, all bedside nursing should be done by practical nurses and by nurses' aids. Small schools of nursing education should be eliminated, and registered nurses should be graduated from large medical centers, with emphasis on university training instead of training in bedside nursing. According to this idea, most nurses of the future would occupy executive positions and have relatively little to do with the care of the patient. This point of view would appear to be extremely shortsighted. The graduates of the larger schools in teaching centers. In many instances, they do blood counts and urine examinations, give intravenous injections, and carry out many other procedures often performed by interns in large medical centers. Nurses with this type of training are invaluable in the care of patients. However, there are many things that nurses have done in the past that could very well be done by individuals with less training. For example, it is difficult to see why a nurse should have to take temperatures, make beds, give baths, and carry bed pans. Functions of this sort could easily be carried out by practical nurses or nurses' aids. On the other hand, there is need for very highly trained nurses with university training, to fill various executive positions in hospitals, and teaching positions in schools of nursing education. There would appear to be a need for the following three types of nurses:

1. The practical nurse or nurses' aid who can perform functions that do not require a long period of special training.

2. The registered nurse with three years of training who is capable of supervising all activities concerned with the nursing care of patients.

3. The registered nurse with college training, who is capable of filling important executive positions and teaching in nursing schools.

The training should be worked out in such a way that the registered nurse with three years of training

may secure credit in the event that she wishes to proceed later with college training.

THE JOINT COMMISSION OF ILLINOIS FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT—The American Medical Association approved the establishment of a National Commission for Improvement of the Care of the Patient. A few months ago, Mr. Leo Lyons, the Superintendent of St. Luke's Hospital, called together representatives of the Illinois State Medical Society, the Illinois Hospital Association, the Illinois State Nurses' Association, and the Illinois State League of Nursing Education to determine the desirability of establishing such a commission in Illinois. The purposes and objectives of this organization are defined as follows: "The major purpose of this commission is to stimulate, implement, assist in, and *sponsor* activities which will contribute to the provement of the care of the patient as may be mutually satisfactory to the appointing organizations.

"To achieve this objective, the commission performs as a service agency to the parent organizations. It shall be the intention of the commission to obtain a better understanding of the problems and programs of all represented groups; to serve as a source of information on trends within the programs of the participating organizations; to facilitate the development of a more unified public relations approach to the participating organizations; to explore the needs for and stimulate studies in areas of patient care in which the organizations participate; and to perform such functions and carry on such activities contributing to the major objectives as may be mutually satisfactory to the appointing organizations and to the commission."

The proposed administrative regulations provide for membership as follows:

"A. The appointing Organizations shall consist of the Illinois State Medical Society, Illinois Hospital Association, Illinois State Nurses' Association and Illinois State League of Nursing Education.

"B. The *Appointed Membership* shall consist of 4 representatives of professional nursing, 4 representatives of the Illinois State Medical Society and 4 representatives of the Illinois Hospital Association.

"The 4 representatives from professional nursing are to be 2 from the Illinois State Nurses' Association and 2 from the Illinois State League of Nursing Education. Selection of representatives with breadth of experience and interest is to be the responsibility of the Appointing Organizations.

"The 4 representatives of the Illinois State Medical Society are to include members of the American College of Surgeons, the American College of Physicians and the American Academy of General Practice.

"The 4 representatives of the Illinois Hospital Association are to include representatives actively concerned with the Illinois Protestant Hospital Association and the Illinois Conference of the Catholic Hospital Association.

"C. Ex Officio Membership shall be:

a. The President of the Illinois Hospital Association, the Illinois State Medical Society, the Illinois State Nurses' Association and the Illinois State League of Nursing Education.

b. The editors of the official journals of the Appointing Organizations.

c. The executive secretaries of the Appointing Organizations."

The Illinois State Medical Society was invited to participate in this Commission through the Council, and the Council referred the matter to this Committee. After due consideration, we recommended to the Council that they participate in the Commission.

At the first meeting, the superintendent of one of the leading hospitals proposed that the main function of the Commission should be to devise ways and means of keeping nurses in hospitals. It had previously been decided that the Commission should confine its deliberations first to the nursing problem. The superintendent in question felt that hospital schools of nursing education should train nurses only for work in hospitals. He was informed that the medical profession would have no interest in the Commission if such an interpretation were to be placed on its functions. He was further informed that schools of nursing education should consider it their duty to train nurses for all fields of nursing activity. The Commission decided to consider the nursing problem in its broader sense. There are many factors involved in the care of the patient besides nursing care. But in view of the acuteness of the nursing problem and the limitations of time, it was decided to confine initial considerations to nursing. Although the impetus for the establishment of the Illinois Commission was provided by the Illinois Hospital Association, the Committee on Medical Education and Hospitals felt very strongly that the Illinois State Medical Society should participate and contribute in every way possible to the development of plans for improving the care of the patient.

HEALTH INSURANCE—It is very important that the medical profession contribute in every way it can to the development of voluntary health insurance plans. The greatest antidote for compulsory health insurance is voluntary health insurance. The Chicago Blue Cross plan and the Chicago Blue Shield plan have expanded rapidly and already cover many counties in the State. The Chicago Blue Shield plan has already become the Illinois Plan. The Illinois State Medical Society and the Chicago Medical Society have gone on record as favoring the development of all desirable types of voluntary health insurance, including those of non-profit organizations like Blue Cross and Blue Shield and those of the commercial insurance companies. It is our hope that the commercial carriers will enter actively the field of health insurance with the knowledge that they will receive the full support of the medical profession. It is hoped that the voluntary health insurance plans will make no effort to establish rigid fee schedules for the whole profession, and thus control the practice of medicine.

POSTGRADUATE MEDICAL EDUCATION—The continuing education of the physician is one of the most important phases of medical education. The facilities for postgraduate medical training provided by the Illinois State Medical Society and the Chicago Medical Society have continued along the lines indicated in our report for 1949. The most important phases of this program include the following:

1. Postgraduate days arranged by the Illinois State Medical Society in various parts of the State.
2. Scientific programs of County Medical Societies.
3. The annual meeting of the Illinois State Medical Society, which is designed primarily for the general practitioner.
4. The Annual Clinical Conference of the Chicago Medical Society, which is also designed primarily for the general practitioner.
5. Intensive postgraduate courses arranged by the Chicago Medical Society and by various medical schools.
6. Numerous scientific meetings of various special societies in the city of Chicago.
7. The annual meeting of the Mississippi Valley Medical Society, which is arranged primarily for the general practitioners of Illinois, Iowa and Missouri.
8. Annual meetings of various national medical societies in the city of Chicago, most of which are open to all physicians.

THE MEDICAL SCHOOL PROBLEM—Chicago now has five approved medical schools. These are the medical schools affiliated with Northwestern University, the University of Chicago, the University of Illinois, and Loyola University, and the Chicago Medical School which is not affiliated with any university. The Chicago Medical School was formally approved November 9, 1948. All of the Chicago schools have extensive plans for expansion. There are now 71 approved schools in the United States, and nine in Canada. The schools with the largest number of graduates during 1948-49 were Illinois, 158; Jefferson, 150; Harvard, 141; and Northwestern, 130. In the Journal of the American Medical Association for September 3, 1949, is given a comprehensive report of medical education in the United States and Canada. The following quotation is pertinent concerning approved medical schools:

"The approval of the Chicago Medical School applied to all students who were regularly enrolled in the first four years of the medical school course at the time the school was approved in November 1948. The approval did not apply to previous graduates or to students in the required intern year who had completed their formal training at the school prior to the date on which it was approved. The Chicago Medical School does not grant the degree of Doctor of Medicine until the completion of a year of internship. The first class to graduate as graduates of an approved school will be the one that graduates in the spring of 1950.

"The basic science schools of North Dakota and South Dakota remain on probation.

"Three Medical schools formerly privately owned by non-profit corporations are merging with State universities during the coming academic year. Syracuse University College of Medicine and Long Island College of Medicine will become parts of the State University of New York. The Southwestern Medical College on September 1, 1949 became a branch of the University of Texas and changed its name to the Southwestern Medical School of the University of Texas. No change of name has been announced by either Syracuse or Long Island.

"The merging of these three schools with state universities will reduce the number of medical schools owned by private non-profit corporations from forty-four to forty-one and will increase the number of publicly owned schools from thirty-four to thirty-seven."

The following tables give a brief summary of the number of medical students from 1905 to 1949:

SCHOOLS, STUDENTS AND GRADUATES IN THE UNITED STATES, 1905-1949

*Students in the required intern year are not included.*

| | *Schools* | *Students** | *Graduates* |
|---|---|---|---|
| 1905 | 160 | 26,147 | 5,606 |
| 1910 | 131 | 21,526 | 4,440 |
| 1915 | 96 | 14,891 | 3,536 |
| 1920 | 85 | 13,798 | 3,047 |
| 1921 | 83 | 14,466 | 3,186 |
| 1922 | 81 | 15,635 | 2,529 |
| 1923 | 80 | 16,960 | 3,120 |
| 1924 | 79 | 17,728 | 3,562 |
| 1925 | 80 | 18,200 | 3,974 |
| 1926 | 79 | 18,840 | 3,962 |
| 1927 | 80 | 19,662 | 4,035 |
| 1928 | 80 | 20,545 | 4,262 |
| 1929 | 76 | 20,878 | 4,446 |
| 1930 | 76 | 21,579 | 4,565 |
| 1931 | 76 | 21,982 | 4,735 |
| 1932 | 76 | 22,135 | 4,936 |
| 1933 | 77 | 22,466 | 4,895 |
| 1934 | 77 | 22,799 | 5,035 |
| 1935 | 77 | 22,888 | 5,101 |
| 1936 | 77 | 22,564 | 5,183 |
| 1937 | 77 | 22,095 | 5,377 |
| 1938 | 77 | 21,587 | 5,194 |
| 1939 | 77 | 21,302 | 5,089 |
| 1940 | 77 | 21,271 | 5,097 |
| 1941 | 77 | 21,379 | 5,275 |
| 1942 | 77 | 22,031 | 5,163 |
| 1943 | 76 | 22,631 | 5,223 |
| 1944 | 77 | 23,529 | 5,134 |
| 1944 (second session) | 77 | 24,666 | 5,169 |
| 1945 (to June 30) | 77 | 24,028 | 5,136 |
| 1946 (to May 31) | 77 | 23,216 | 5,826 |
| 1947 (to June 30)† | 77 | 23,900 | 6,389 |
| 1948 (to June 30) | 77 | 22,739 | 5,543 |
| 1949 (to June 30) | 78 | 23,670 | 5,094 |

**Includes figures for schools of the basic medical classes*

*†Includes figures for additional classes*

STUDENTS IN THE MEDICAL AND BASIC SCIENCE SCHOOLS IN UNITED STATES

1931-1949

*Students in the required intern year are not included*

| | *Freshman* | *Sophomore* | *Junior* | *Senior* | *Total* |
|---|---|---|---|---|---|
| 1930-1931 | 6,456 | 5,538 | 5,080 | 4,908 | 21,982 |
| 1931-1932 | 6,260 | 5,462 | 4,932 | 4,885 | 22,135 |
| 1932-1933 | 6,426 | 5,479 | 5,017 | 4,948 | 22,466 |
| 1933-1934 | 6,457 | 5,571 | 4,988 | 4,937 | 22,799 |
| 1934-1935 | 5,356 | 5,624 | 5,142 | 4,905 | 22,888 |
| 1935-1936 | 6,605 | 5,458 | 5,230 | 5,020 | 22,564 |
| 1936-1937 | 5,910 | 5,269 | 5,140 | 5,158 | 22,095 |
| 1937-1938 | 5,791 | 5,225 | 4,986 | 5,036 | 21,587 |
| 1938-1939 | 5,764 | 5,160 | 4,947 | 4,921 | 21,302 |
| 1939-1940 | 5,794 | 5,177 | 4,921 | 4,894 | 21,271 |
| 1940-1941 | 5,837 | 5,254 | 4,969 | 4,849 | 21,379 |
| 1941-1942 | 6,218 | 5,406 | 5,087 | 4,942 | 22,031 |
| 1942-1943 | 6,425 | 5,828 | 5,278 | 5,100 | 22,631 |
| 1943-1944 | 6,561 | 6,071 | 5,640 | 5,257 | 23,529 |
| 1944 (2nd session) | 6,648 | 6,140 | 6,084 | 5,794 | 24,666 |
| 1944-1945 | 6,523 | 5,979 | 5,700 | 5,826 | 24,028 |
| 1945-1946 | 6,060 | 5,750 | 5,751 | 5,655 | 23,216 |
| 1946-1947* | 6,564 | 5,575 | 5,767 | 5,994 | 23,900 |
| 1947-1948 | 6,487 | 5,758 | 5,154 | 5,340 | 22,739 |
| 1948-1949 | 6,688 | 6,194 | 5,702 | 5,086 | 23,670 |

**Includes additional classes.*

The development of new medical schools in this country is summarized in the report in the Journal of the American Medical Association as follows:

"The University of Washington School of Medicine in Seattle will have completed the organization of its full four year program during the coming academic year and will graduate its first class in the spring of 1950. This school has requested approval by the Council and the Association of American Medical Colleges and will be visited by representatives of these bodies after all four classes are in attendance. The Council announced in the Internship and Residency Number of the Journal (May 14, 1949) that, pending action by the Council, students who graduate from the University of Washington School of Medicine in 1950 will be considered for purposes of internship appointment as if they had graduated from an approved medical school. Hospitals approved for intern training will not lose their approved status if they accept these students for internship.

"The 1949 Florida legislature passed an act authorizing the establishment of a medical school as a part of the University of Florida at Gainesville. No funds were appropriated however.

"In West Virginia the 1949 legislature authorized the establishment of an interim committee to study the entire problem of medical education in West Virginia, including the possibility of establishing a four year school. This committee will report to the next legislature which meets in January, 1951.

"The Mississippi State Medical Association and the faculty of the University of Mississippi School of Medicine voted unanimously during the past year to request the establishment of a four year medical school. The governor of the state has announced that he is in favor of the project. The chancellor of the university has appointed a committee to study the problem, and it is hoped that the 1950 legislature will appropriate funds to finance the necessary construction.

"The North Carolina legislature during the past year increased the appropriation for the construction of the plant for the projected four year medical school to $8,500,000. This figure does not include an additional $1,000,000 that has been appropriated for a dental clinic building. Construction will begin in the fall of 1949. It appears now that instruction in the third year will be started in the fall of 1952 or 1953.

"The Medical School of the University of California in Los Angeles has begun preparation of the site for its buildings, and it is hoped that the school will be open in the fall of 1952.

"The New Jersey State Medical Society in May, 1948, passed a resolution requesting the governor of the state to appoint a survey committee to study the problem of establishing a medical school as a department of the State University at Rutgers. In April, 1949, the governor completed the appointment of this committee, which will report to him at the conclusion of its studies.

"Missouri and North Dakota are actively studying the possibility of expanding to four year programs, but no definite plans have been developed."

It may be seen that with the number of new schools contemplated and with the increase in the number of students in schools already in existence, the production of doctors will be adequate to take care of the increase in population.

The cost of medical education continued to increase and was a source of great concern to the privately endowed schools. The cost per student per year in 1949-1950 varied from $917.00 to $9,500.00 with an average cost of $2,577.00. During the current year, tuition fees will account for only 22.8% of the budgets of the medical schools. Although student fees have risen on the average from $513.00 for 1948-1949 to $548.00 for 1949-1950, it is obvious that students' fees cannot be increased enough to meet rising costs, and additional sources of revenue must be sought. It is sincerely hoped that new money for the medical schools will be forthcoming from private sources so that government funds will not have to be used. Control of the production of doctors by the government would be an important step in complete political domination of medicine. It is significant that only 44 of the 71 medical schools in the country are privately endowed.

## OTHER PROBLEMS

Other important problems have been considered by the Committee on Medical Education and Hospitals, but they cannot be discussed adequately in a report of this character until a final decision is reached.

W. O. THOMPSON, M. D., *Chairman,* A. C. IVY, M. D., HARLAN ENGLISH, M. D., *Committee on Medical Education and Hospitals.*

DR. W. O. THOMPSON, Chicago: Dr. Ivy who is a member of this Committee expected to be here on account of a complaint from Whiteside County. Mrs. Ivy was operated on yesterday and Dr. Ivy felt that he could not leave. I am sure you will all be glad to hear from the new Dean, Dr. Stanley Olson, University of Illinois, who will say something about the complaint.

DR. STANLEY OLSON, Chicago: Dr. Thompson, President Stevenson and members of the House of Delegates: It is a pleasure for me to be here today to speak to you for a few minutes. Dr. Ivy sends his regrets that he could not be here personally. All of you, I am sure, read the report of Dr. Thompson's Committee in the Minutes of the Society that you have printed in the Handbook in which certain charges were made against a certain hospital. The hospital in question is the one known as the Research and Educational Hospital of the University of Illinois, which is the reason I am here. I would like to say one or two things as sort of a prelude. Many of you, I am sure, read recently that the Research and Educational Hospital celebrated its 25th anniversary about a month ago. That hospital was built in 1925. The idea was conceived by the Department of Public Welfare to be used in conjunction with the University of Illinois in the study of some of the problems that were coming to the Department of Public Welfare which they could not handle and at that time many of these people became expensive charges to the state of Illinois. The name Research and Educational Hospital typifies those two functions, namely, research and training of doctors. Many of you also know that the number of beds that we have at the hospital has been very limited. The kind of service that we have been able to provide has been limited to the total number of beds available. We have tried to make the beds available to patients used for teaching and research. I think that is very important that a hospital and a tax supported school should be opened for criticism by the physicians of the state. We not only welcome that criticism but we feel it is the means by which we can improve our position in relation to the physicians in the state of Illinois. I have been at the University for less than two months and my own feeling is this. The state of Illinois has provided a University where these functions can be carried out for the state as a whole and not for any geographic area. I am pleased to find that there are a number of members of the faculty who have stated the same position, namely, that the position of the University of Illinois is to the state as a whole.

I should like to apologize for any ill manners which we have shown to the physicians of the state and to apologize for any rudeness or discourtesy to any patient who has been referred to the Research and Educational Hospital. Discourtesy is something that is inexcusable. I can not promise it will not happen again because our staff is a large one and things happen over which we have no control. To the best of our ability we recognize that we have responsibility in a state hospital even more than in a private hospital and we have an obligation to the physicians of the state who refer patients to us.

I think our situation at the University of Illinois is one of which we can be very proud. We have physical facilities that are very well developed and equal to any in the state. We have a great medical center which is being developed into one of the finest cities in the state of Illinois. I am proud as I am sure you will be proud of it. I will pledge my faith that I will do everything in my power to make the Research and Educational Hospital function as a hospital which is useful to you and other people of the state of Illinois. I look forward to the development on the campus of a place in which doctors can be trained in realistic fashion as doctors of medicine. I look forward to an increasing and active research. I look forward to an environment in which patients can be treated effectively with high regard for their individuality.

THE PRESIDENT: I think that was a grand supplementary report. The supplementary reports must be handed with the original report to the Reference Committee. At that time we will take proper action.

## REPORT OF THE COMMITTEE ON MEDICAL BENEVOLENCE

There is continuing daily evidence of the need and value of our Benevolence Fund. The hazards and uncertainties of life in this strange world leaves very little to any one individual's choice, and the most prosperous may, without fault of his own, find himself on the very lowest rim of "Fortune's Wheel". This fund, established in 1940, has without question been the source of comfort and relief to many of our colleagues as well as their families and it is doubtless one of the finest activities of our Society. A colleague restored to health or comforts provided in case of a terminal illness by those bound by fraternal and professional ties has the grateful knowledge that somewhere some of his friends are thoughtful of his welfare.

With our new arrangement of securing funds and with the continuing assistance of our Women's Auxiliary, the amount in our treasury is reaching a healthy state, and it would seem that with the value of our dollar so much diminished we might well give some thought toward increasing our maximum benefit. At this time, twenty-two beneficiaries are receiving monthly checks ranging in amounts from $30.00 to $50.00.

Over the ten-year period approximately sixty (60) beneficiaries have been aided for varying periods of time. The maximum number on the list at any one time was twenty-five (25). Several of the beneficiaries first accepted are still on the list. The amount contributed per month ranges from $900 to $1,000. In the ten years, nearly $40,000 has been contributed. We believe that unless one is really familiar and well acquainted with the needs of those making application, it is difficult to visualize the great benefits which they receive. Space does not permit much detail.

One young man in early life came down with minimal tuberculosis. By action of the Council, he was provided with sufficient funds to have sanitarium care

where he made a good recovery and he is now in active practice.

The wife of a well known teacher who died after three years of invalidism was left with very little support. She received for quite some time $40.00 per month and, when at the age of 91 she fell and fractured a hip, the Council allowed payment of $100.00 a month in her final illness.

We feel that the Society is doing a splendid job in contributing to the needs of these worthy members of our Society. It is well to remember that charity is twice blessed, blessing him that gives as well as the one who receives.

Respectfully submitted, *Committee on Medical Benevolence,* OSCAR HAWKINSON, M. D. *Chairman,* L. O. FRECH, M. D., HAROLD M. CAMP, M. D.

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### REPORT OF THE COMMITTEE ON MEDICAL TESTIMONY

To our great satisfaction, the work of the Committee has been greatly decreased during the past year. Only two of our members have been called because of complaints entered against them; one of these appeared a second time. In both instances, the question involved testimony in personal injury suits. The Committee in its conclusion decided that a letter of admonition, calling attention to the gravity and importance of expert testimony, was sufficient for these two offenses.

In January, 1949, the meeting of the Committee on Personal Injury Practice of the Chicago Bar Association was held in their spacious quarters. Judge Schnackenberg and the Chairman of the Committee on Medical Testimony were invited to attend as its guests. The following subjects were discussed:

1. Loss of valuable time by doctors when called to testify in court with embarrassment of both physician and lawyer.
2. Reluctance on the part of lawyers to subpœna physicians for fear that they will be uncooperative in their testimony—harmful rather that helpful.
3. Inability of lawyers to give doctors much previous notice because of the uncertainties of the trial call and unexpected settlements.
4. Resentment on the part of doctors to be badgered and treated with less dignity than is their due.
5. The difference in the fee paid to the so-called expert witness as against the set fee paid to the one who is supœnæd.

The Committee then made a study of this discussion, and with the thought in mind that pleasant relationship between the two professions should be cultivated, recommended that a committee composed of members from the Bar Association and an equal number from the Medical Society be appointed to study complaints and iron out any difficulties that may arise from the situations herein indicated. The President of the Bar Association under direction of the Board of Managers then appointed this Committee which is made up of the Cook County members of the State Committee on Medical Testimony with the following members of the Chicago Bar Association:

A. J. Bowe, Esq., Daniel P. Nagle, Esq., Judge Elmer J. Schnackenberg, Circuit Court, Judge Donald S. McKinlay, Superior Court, Erwin W. Roemer, Past President of the Bar Association as Chairman.

On October 20, 1949, Mr. Erwin Roemer, Chairman, of the Committee called a meeting of this group in the rooms of the Chicago Bar Association for the purpose of making a study and report of these problems. This study is still in progress and no complete report is yet available. It is gratifying that the Bar Association has taken such an active interest in these problems and we feel that only good can result. At irregular intervals, a letter regarding the activities of our Committee will be sent to the Judiciary and the various hearing bodies of the State. This letter is now in the process of preparation and will be mailed at an early date.

Respectfully submitted, *Committee on Medical Testimony,* OSCAR HAWKINSON, *Chairman,* EVERETT P. COLEMAN, M. D., WARREN W. FUREY, M. D., ARTHUR F. GOODYEAR, M. D., HARRY A. OBERHELMAN, M. D., WALTER L. PALMER, M. D., E. H. WELD, M. D., M. T. HORSMAN, M. D.

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### REPORT DELEGATES TO THE A. M. A.

In keeping with the action of the delegates of the Illinois State Medical Society in 1949, your delegates to the American Medical Association desire to make the following report regarding the transactions of the House of Delegates of the A. M. A. at the annual and clinical sessions of 1949.

The House of Delegates of the American Medical Association is the policy making body of this great organization. It consists for the most part of elected representatives of the membership of constituent state associations, the exceptions being representatives of the Armed Forces, U. S. Public Health Service, and of the special medical societies. The objective of it is to try to achieve for our people the best medical care in the world. Too many physicians fail to realize the mechanism by which it functions, nor the colossal task that confronts it. The varied problems nor the time effort, investigation and careful thinking devoted by its Board of Trustees, Councils, Officers and Committees as well as by the membership are not realized by the rank and file of the membership. The multitudinous problems constitute a large agenda for the House of Delegates to consider. While the annual and clinical sessions make it possible to distribute this agenda over two meetings, it still leaves an enormous amount of material to be transacted at each meeting. The Journals of the A. M. A. immediately following carry an excellent editorial by the Editor of the Journal as well as a long and detailed report of the action of the House on the many reports of the Board of Trustees, Council and Committees, and resolutions acted upon by the House. It is impossible in the few pages alloted to us in this Handbook to make a detailed report of the multitudinous affairs transacted by the House. We will herewith attempt to enumerate a short summary

of these transactions, but we respectfully request every member of the medical profession to read those reports.

THE ANNUAL MEETING—In the opinion of many physicians many of the reports and resolutions which were introduced and adopted in the House at the annual meeting will affect the practice of physicians in the medical care of the people in the United States. Included herewith are some of the important items on the agenda.

1. The Judicial Council presented a complete report of a restatement and revision of the principles of medical ethics. The report was promptly adopted by the House of Delegates. Your delegates respectfully ask that this report be carefully studied by every member of the medical profession. We especially commend to you the parts relating to groups and clinics, including contract practice.

2. Hospitals and the practice of medicine.

3. Prepayment medical care.

4. The classification of medical schools.

5. Resolutions on medical education.

6. Graduate and postgraduate education for general practitioners.

7. Two-year rotating internships.

8. A resolution to the effect that the American Medical Association should insist the hospitals should make available to general practitioners all of their facilities for the care of the sick.

9. Recommendation that a committee of the House of Delegates be established to consider the whole intern problem.

10. Resolution that the Council on Medical Education and Hospitals extend its inspection service to all hospitals.

11. The question of establishing dues in the American Medical Association was referred to the Board of Trustees for a report at the interim session.

12. Resolution urging the American Medical Association to appoint a committee to study the problem of displaced physicians.

13. Report from the Council on National Emergency Medical Service in reference to having secured the establishment of a physician at an important level in the office of the Secretary of Defense.

14. Report of the Co-ordinating Committee.

15. For the Distinguished Service Medal three names were presented, Drs. Alfred Blalock, Seale Harris and Shields Warren. Dr. Harris was elected.

16. Address by Whitaker and Baxter, Public Relations Councilors of the A. M. A.

17. Election of Dr. Elmer L. Henderson, President-Elect.

18. Dr. Ernest E. Irons installed as President.

The reports of the Board of Trustees, Officers, Councils and Committees and many varied resolutions constitute the main items of the annual session, and should be read by all our members.

THE CLINICAL SESSION—The Clinical Session had a large agenda with numerous problems for consideration, a short summary of which is here included.

1. The General Practitioners' Award: Three names were nominated by the Board of Trustees to be voted upon by the House of Delegates. Dr. Andy Hall of Mt. Vernon, Dr. Carlisle Bunny Hare, Spearfish, S. D., and Dr. Thomas Edward Rheine of Thornton, Ark. Dr. Andy Hall was elected.

2. The question of changing the by-laws of the American Medical Association which was discussed in June, so as to make a provision for dues for the members of the American Medical Association was referred to a Reference Committee on Constitution and By-Laws. The Committee after careful study and deliberation recommended the necessary changes that should be made so as to make it possible for the Association to charge annual dues. The House voted these changes in the constitution and by-laws. The Board of Trustees recommended twenty-five dollars dues for the coming year which was also adopted by the House of Delegates.

3. The President, Dr. Ernest Irons, delivered a stimulating address on the Educational Campaign of the Association, and the Social Planners.

4. George N. Craig, National Commander of the American Legion, addresed the House and said that the Legion was opposed to socialized medicine and to any movement to take the government away from the people.

5. Resignation of Dr. Morris Fishbein as Editor of the Journal of the A. M. A. and appointment of Dr. Austin Smith, the Associate Editor, as Editor.

6. Discussion of Senate Bills 1411 and 1453 and also a report on the companion bills S. 1453 and H. R. 5940. These were presented jointly by the Board of Trustees and the Council on Medical Education and Hospitals.

7. Three resolutions were introduced by the delegates of the Illinois State Medical Society. (1) Resolution by Dr. G. Henry Mundt on an appointment of a committee of non-medical men to assist in the American Medical Association's campaign. (2) Resolution by Dr. Mather Pfeiffenberger on general officers eligible for election as President-Elect. (3) Resolution presented by Dr. Charles H. Phifer for Dr. Andrew C. Ivy recommending the formation of a Junior American Medical Association for medical students and interns.

8. The House of Delegates heard a report on the American Medical Association's national campaign.

9. Your attention was called in the session of the annual meeting at Atlantic City to a report of the Committee on Hospitals and the Practice of Medicine. The Board of Trustees in reviewing this report, its recommedations and action by the House of Delegates believed that the report as acted upon by the House could be misconstrued. It was their opinion that consideration should be given at this meeting of the House of Delegates to the repealing by the House of Delegates of the report of the Reference Committee on Hospitals and the Practice of Medicine, by virtue of which an amended and revised report was adopted by the House of Delegates in June, 1949. The matter was accordingly referred to a Reference Committee which gave long and detailed consideration to this section of the report which is familiarly known as the Hess Report. The Reference Committee recommended that the special committee on Hospitals and Practice of Medicine (known as the Hess Committee) be reactivated, that

the original report of that Committee be referred back to it for further study, in view of the present legal opinion relating thereto and that this Special Committee report to the House of Delegates of the Association at the annual session in June, 1950.

10. A resolution was again introduced by Dr. Wood of Tennessee to study the status of veterans with nonservice connected illnesses and report back to the House at its next session. A resolution of this type has been introduced at each session of the House for several years. The Reference Committee's report on this resolution was freely discussed, after which it was moved that the Speaker appoint a Committee of five members of the House of Delegates to study the problems connected with nonservice-connected illnesses and report back to the session at San Francisco.

The very excellent reports of the Board of Trustees, Officers, Councils and Committees, as well as many other resolutions constituted the remaining agenda of this meeting, and should be carefully read.

Respectfully submitted, CHARLES H. PHIFER, M. D., *Chairman of the 1949 Delegation,* BERNARD KLEIN, M. D., WILLIS I. LEWIS, M. D., MATHER PFEIFFENBERGER, M. D., EDWARD H. WELD, M. D., EVERETT P. COLEMAN, M. D., H. KENNETH SCATLIFF, M. D., G. HENRY MUNDT, M. D., F. H. MULLER, M. D., ROBERT H. HAYES, M. D., HAROLD M. CAMP, M. D., *Delegate—Interim Session, Delegates to The American Medical Association.*

## REPORTS OF COUNCIL COMMITTEES

### REPORT OF ADVISORY COMMITTEE SURVEY ON CHILD HEALTH, AMERICAN ACADEMY OF PEDIATRICS

The Advisory Committee on Child Health Service has held no meeting in the past year, all affairs having been handled by correspondence.

The main objective of the group has been the completion of the State Survey on Child Health Services conducted by the American Academy of Pediatrics.

This has been completed and in the original form was too voluminous for publication. The report has been revised and abstracted in such form that it might be published in the State Medical *Journal.*

The Committee has approved this work and submitted the material to the Council and it now is in the hands of the Editorial Board.

The report contains excellent material and it is the sincere hope of the group that the work may be published shortly.

Respectfully submitted, JOHN F. CAREY, M. D., *Chairman, Advisory Committee on Child Health Survey, American Academy of Pediatrics.*

### REPORT OF THE COMMITTEE ON FETUS AND NEWBORN

There has been no meeting of this committee for two years. The Committee on Fetus and Newborn, of the American Academy of Pediatrics has prepared a short very well organized manual entitled "Standards and Recommendations for Hospital Care of Newborn Infants"—"Full Term and Premature," which is available to any physician or hospital by writing Clifford G. Grulee, M. D., Secretary of the American Academy of Pediatrics, 636 Church St., Evanston, Illinois. Price fifty cents.

The Chicago area members of the Committee met in September, 1949, and have proposed regulations to be put into effect in the Cook County area hospitals patterned after the Requirements for Maternal Care. Its title and wording is as follows:

Suggestions to Hospitals for Minimum Requirements as to the Professional Qualifications of the Pediatric Staff and the Conduct of the New Born Nursery.

1. CONTROL.
   All new born nurseries should be in charge of a qualified pediatrician.
2. The pediatrician in charge shall have at least two of the following qualifications:
   (a) Special training in pediatrics for a period of one year in a hospital approved for pediatric internship.
   (b) Affiliation with an accepted medical college in a teaching position in the department of pediatrics or with an approved organization giving pediatric care to infants.
   (c) Membership in the American Academy of Pediatrics or at least one of the special Pediatric Societies or Certification by the American Board of Pediatrics.
   (d) Specialization in the practice of pediatrics for at least five years or equivalent training or experience.

Pediatrician who qualified for the above may be in charge of the nursery or act as consultant.

3. ORGANIZATION.
   It will be the duty of the pediatrician in charge of the nursery or the consultant to establish and aid in the enforcement of nursery regulations and to require that all infants be examined and appropriate records be made on the chart under his supervision.
4. CONSULTATION.
   Consultation must be asked for from a qualified pediatrician, or the pediatrician or consultant in charge of the nursery, on the following conditions arising in the new born:
   1. Prematurity. Babies below 4 lbs. 8 oz. or 2041 grams.
   2. Cyanosis.
   3. Persistent vomiting.
   4. Abdominal distention.
   5. Respiratory difficulty.
   6. Convulsions.
   7. Jaundice within the first 24 hours.
   8. Abnormal bleeding.
   9. Sustained temperature of 101 or over, for 24 hours.
   10. Questionable infectious skin lesions.
   11. Diarrhea.

The Chicago area members of the committee feel

that such suggestions will assure better care of the new born. They would have to be approved by the Chicago Hospital Association, the member hospitals, the Chicago Medical Society, the Maternal and Infant Welfare Committee of Cook County. They have been approved by the Chicago Pediatric Society.

Under the Illinois Public Health Service premature care is being expanded as rapidly as facilities and funds are available. The general overall care of the new born in the State of Illinois is good and rapidly improving.

Respectfully submitted, *Committee on Fetus and New Born,* GERARD N. KROST, M. D., *Chairman,* PHILIP L. ARIES, M. D., H. N. SANFORD, M. D., IWAN ROSENSTERN, M. D., GERALD M. CLINE, M. D., JOHN R. VONACHEN, M. D., HOMER F. WEIR, M. D., JAMES B. GILLESPIE, M. D., WALTER M. WHITAKER, M. D.

## REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION

For the past several years your Advisory Committee has been able to report annually a certain amount of progress in this rather difficult field. Practically each year the committee has been able to effect increases in the fee-bill for medical or surgical care, a decrease in the amount of paper work required and an increase in the facilities for medical care for these Public Aid recipients. In other words, the past few years have shown definite progression of the program with increased benefits to both the recipients and the medical profession which is participating in this program. During this time every attempt has been made to protect the interests of the medical profession, as well as the interests of the recipients of medical care, with definite and due concern for the taxpayers who are footing the bill.

This present report is somewhat less optimistic in some respects. It had been thought that by this time there would be at least a moderate increase again in fees for office and house calls and in those allowed for hospital visits. Instead there has been a definite curtailment of expenses in the program and your committee would like to call to your attention some of the problems this has brought about, and some of the reasons accounting for it.

At the last session of the State Legislature the Public Aid Commission submitted its estimate of money needed for the coming biennium, divided up into the categories of Old Age Assistance, Aid to Dependent Children, Aid to the Blind, and General Relief. The budget they submitted had been trimmed to what seemed to be the lowest possible margin, but in spite of this the legislature cut it by $18,000,000.00. Every attempt has been made by the commission to live within this budget but the problems have increased decidedly. The Old Age Assistance Program in particular has been so successful that Old Age Recipients are now expecting and demanding medical care of a type which is naturally rather expensive. But with the decrease in the amount appropriated to the budget there has been an increase in the demand for public assistance care, both medically and generally, in every category. 44,000 persons have been added to the assistance rolls since a year ago. The majority of these are recipients of general assistance and with unemployment brought about by numerous strikes, the number on General Relief is steadily increasing. In fact the entire public assistance load is increasing due to a decline in the general activity throughout the state. It now appears that the deficit instead of being $18,000,000.00 will be perhaps $25,000,000.00 or even more, at the end of the biennium.

Since there is a trend toward an increase in national unemployment this is also being reflected in the State of Illinois, which again adds to the expense of the Public Aid Commission as it has to assume this additional burden. At the present time Illinois unemployment has tripled over the past eighteen months period. Claimants for Unemployment Insurance have more than doubled in the past year. In Cook County unemployment has risen from 52,000 in November in 1948 to 188,000 in November, 1949. Many other figures could be given to cite the difficulties with which the Public Aid Commission is faced, but these will perhaps suffice to present the problem and the situation itself.

Due to the decrease in funds it became necessary for the commission to exhaust every possible means of reducing expenditures and to effect every economy. On this basis the funds allocated for food have been reduced, rental funds have been diminished, and the funds allowed for ordinary personal care such as haircuts, medicine chest needs and similar things have been entirely eliminated. At the present time medical fees have not been reduced, although in almost every other program of this type these would be the first to suffer. The reason it has not been done has been due to the fact that the profession throughout the state and its Advisory Committees have cooperated so effectively with the Public Aid Commission. Every effort has been made, however, to reduce the amount of funds needed for medical care. The use of expensive drugs has been limited wherever possible by the County Advisory Committees. A careful investigation has shown that one of the major expenses has existed in the long term hospitalization of many individuals who are unable to be cared for at home. In order to reduce this hospitalization, some of which was perhaps unjustified, efforts have been made to shorten the hospital stay by means of allowing approval for only two weeks at a time. This has caused additional burdens to fall upon the local Advisory Committees but it has resulted in a decline in the volume of hospitalization of Old Age Assistance recipients for the first time since the program was started. This plan has met with the approval of most of the County Medical Societies and we feel with the majority of the members of the profession. In order to accomplish this it has been necessary to use an increasing number of beds in Nursing Homes, but as these Nursing Homes are being developed over the state they have been able to take care of some of the hospital load. This has given more room for acute

cases in hospitals, and has lowered the overhead decidedly. It has, however, been inconvenient to many doctors and some patients because of the fact that they could not be hospitalized for a longer period of time. On the other hand, many patients were using the hospital in lieu of a County Home and it has been a worthwhile accomplishment in lightening the burdens on the hospitals by eliminating this particular group.

The committee feels that one of the major accomplishments that has been made by this group has been the establishment and furthering of County Advisory Committees. These local groups have had to take on medical leadership and have done so very effectively. They have followed the policy of the State Committee in establishing closer relationships with the County Public Aid Groups, and this has led towards greater efficiency of the program throughout the state. The State Committee has also tried to keep more closely in touch with the County Advisory Groups. This has been accomplished by having the chairman and members of these committees attend meetings of the State Committee from time to time so that the State Committee could get the local viewpoint more effectively, and also present to the county members the problems that the State Committee has to face.

The usual problems have occurred in the past year as they have in the past. Due perhaps more to misunderstanding than anything else, some doctors have been rendering excessive medical care or prescribing excessive amounts of drugs. Your committee, through cooperation with the County Advisory Committees, has done as much as it felt it possibly could in attempts to correct these conditions. Appeals to the doctor whose practices were questioned have been usually quite successful.

The program has still not been accepted in Cook County. In November, 1948 the Public Aid Commission proposed to the Chicago Medical Society that the downstate plan be extended to Cook County, but so far this offer has not been accepted. The chief problem is due to the fact that the Public Aid Commission expects patients when hospitalized to be taken care of by the family physician, or the one to whom he refers the patient. Whereas, those on relief rolls in Cook County are bound by hospital policies locally to put these patients on a ward service where attending men usually take care of them in rotation, and thus the patient has lost his family doctor. It is thought that if the Chicago Medical Society could persuade the Hospital Administrators of Cook County to change this plan it would be to the benefit of the practicing physician in Cook County, and improve the medical care of the patient.

In our plans for the future we still feel that by maintaining cordial relations between the State Advisory Committee and the Commission, and carrying this down also on the county level, we are developing an excellent public relations system for our society. We also feel that when the appropriation deficiencies are remedied, as we hope they will be by the next session of the legislature, that we can go on with the program on an even more effective basis and ultimately obtain increases in fees which will overcome some of the problems existing at the present time.

Respectfully submitted, *Advisory Committee to the Illinois Public Aid Commission,* E. P. COLEMAN, M. D., *Chairman,* EDWIN S. HAMILTON, M. D., JULIUS H. HESS, M. D., HARLAN ENGLISH, M. D., B. E. MONTGOMERY, M. D.

## SUPPLEMENTAL REPORT OF THE ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION

Two months have elapsed since the original report published in the official reports was made. Since then several things have occurred which have complicated the situation quite considerably.

Due to the increasing certainty of a greater shortage of funds occasioned by between 14 and 15% increase in people who have gone on relief because of unemployment, the deficit for the biennium is now calculated in figures varying from 14 to 25 million dollars according to who makes the estimate. In an election year it is quite obviously not going to be a popular procedure to ask for an additional session of the legislature to vote additional taxes for this purpose although additional tax funds may be required, and probably will be, at the beginning of next year. As a result of this problem the Public Aid Commission has made desperate efforts to cut down its overhead and in addition to curtailing the funds allocated for food, shelter, clothing, and so on, is attempting to cut down on the amount of expense in hospitalization and also in the use of drugs. This is particularly important to the Commission because of the recent tremendous increase in the use of the various antibiotics which are quite expensive. As a result there has been a two weeks limitation on cases for hospitalization and recently a demand that all cases have preauthorization before being hospitalized. Furthermore, for a period of several months, particularly the last two months, efforts have been made to check the cost of drugs dispensed with the intention of reducing expenses in this particular field. This has led to the issuing of several new directives which have perhaps been effective from the standpoint of curtailing expenses but which have also been very annoying and irritating to the medical profession. It has increased the irritating annoyance factor to quite a degree and as a result a great many protests have been received throughout the state.

The Advisory Committee, at a recent meeting with the Commission, was able to get the ruling for preauthorization for hospitalization of Public Assistance recipients rescinded to this extent: — it is now in the hands of the local Advisory Committees and they can continue it if they wish to. Therefore it may be continued in some counties if it meets with local medical society approval whereas, in counties where it has met with objection and resistance, it will go back to the former method.

A meeting is already planned between the Advisory Committee and the Commission for the following week at which time it is hoped to get a more liberal attitude on the part of the Commission toward the price of

dispensed drugs, especially antibiotics. In order to affect this, your Committee would appreciate a resolution from the House of Delegates directing us to ask for a readjustment of the prices of drugs, and antibiotics in particular.

Respectfully submitted, E. P. COLEMAN, M. D., *Chairman,* EDWIN S. HAMILTON, M.D., JULIUS H. HESS, M. D., HARLAN ENGLISH, M. D., B. E. MONTGOMERY, M. D.

## REPORT OF ADVISORY COMMITTEE TO THE UNITED MINE WORKERS WELFARE AND RETIREMENT FUND

At the meeting last year, the United Mine Workers Welfare and Retirement Fund was just being inaugurated and had been tried out in only a few parts of the country and in some sections of Illinois. It was the first major attempt by one of the large labor organizations to have its own fund for the care of its members when sick. This fund was planned on rather an elaborate scale, established as a Welfare and Retirement fund to serve four separate purposes with four separate divisions: (1) Pension; (2) Disability Benefit, including assistance for widows and orphans; (3) Death Benefit; (4) Medical, Health and Hospital Care. It was also quite certain that this plan would be used as a pattern by many of the other huge organizations which were even then starting plans for similar union projects. While the medical profession is always in sympathy with any attempt to give the members of labor organizations the best possible medical care, it is also aware of the fact that many of these organizations, due to the possibility of their being poorly advised and not understanding medical problems, might tend to perpetuate the evils and the unsatisfactory conditions which have existed in small mining communities where medical care was furnished by the check-off system with the cooperation of a company doctor. Therefore, this committee was appointed to advise with the executive group of the United Mine Workers for this District and to cooperate with them to the best of our ability, also to help them insofar as we were able, to develop a satisfactory working plan which would also be satisfactory to the members of the medical profession. Your committee has worked with these principles in mind.

The plan started out with the intention of putting all the doctors who worked in mining communities on a list, if they would cooperate with the union. An overwhelming majority subscribed without hesitancy. Those who are in areas where no mining is done were not on this list but could take care of a miner or a member of his family in an emergency and be paid for it on the basis of the Veterans Bureau fee bill. However, the plan was to have the individual miner and his family go to a doctor of their choice. Each one had to list a doctor whom he regarded as his family physician and to whom he could go without any further introduction or any particular paper work. The doctor was encouraged to refer his patients to specialists for their particular attention when the need for this type of service existed, and to hospitalize them at ward rates when such need arose.

The policy of the welfare fund has been to not establish a fee bill since doctors' fees are so variable over the state and in particular over the sections of the entire country where mining is a major industry. Instead of a fee bill we were given the suggestion from their National Advisory Committee that they would be willing to approve fees if charges were submitted on the basis of those used by the Veterans Administration. The Veterans Administration fees are in some respects quite satisfactory and in others they seem to be too low for present expenses and living conditions. They are more in line with depression time fees than those in existence at the present time. On the other hand, many of these miners are only employed part-time and in some places at a wage which does not give them too much income when working only on a part-time basis. The fee bill has been the source of a considerable amount of complaint and difficulty but in most areas of the state has been ironed out quite satisfactorily, and it is thought that most of the men doing this type of work are reasonably well satisfied with it. Since the strike, with the resulting loss of income for the fund, the plan has been temporarily discontinued, largely due to the fact that court procedures have tied up the remainder of the fund. Whenever the strike is settled, and at the time of this writing it appears to be close to settlement, the program will be re-established on a piecemeal basis. It will probably provide hospital care only in the beginning, and later extend this coverage when the funds are increased sufficiently to make it practical to do so.

The original principle of the plan was to furnish hospitalization and major surgery for not only the retired and dependent miners and their wives but also for the working miner and his family. The fund has not yet been able to take on such problems as dental or medical care in the home for the working miner, it being felt that the average man who is employed can take care of his own minor illnesses but would be in need of aid when major disabilities occurred requiring hospitalization. On this basis the plan has been quite reasonably satisfactory.

There have been several meetings of the committee with the Executive Group of the Mine Workers under the leadership in this District of Dr. C. A. Z. Sharp. Our relations with this group have been quite satisfactory, and while we have not been able to accomplish all the things we have desired, we have been able to straighten out a number of problems in several ways. Due largely to misunderstandings, there have been occasions when members of our society have rendered bills which the welfare fund representatives thought were excessive. The usual tendency under these circumstances with those not familiar with medical problems has been to immediately sever all relationship with the doctor who might have committed an error of judgment in perfectly good faith. The committee has been able to rectify several problems along this line. The paper work, which has been kept down to a reasonable minimum, is still somewhat complex and it is the hope of the committee that in the course of a little time this can be reduced considerably. A few County Advisory

Committees have met with Dr. Sharp, and some have been attended by members of this committee with the idea of explaining the principles of the plan and to try to iron out various problems which have arisen. Many such problems have come up due to the fact that local union secretaries did not understand the details involved or in some instances could seldom be located. The initial idea of having all hospitalization approved by calling the office at St. Louis was discontinued before the temporary cessation of the program, and further methods of simplification will probably be effected.

Your committee feels that since the large labor organizations in the country are going into the health and welfare field on a big scale, our cooperation with the United Mine Workers has served to show that the medical profession can and will cooperate with organized labor on a satisfactory basis. We have shown them that it is possible to render good service at reasonable fees and have demonstrated that there is no necessity for the Federal Government or any other outside agency to come between the doctor and his patients. The committee is trying to improve the present harmonious relationship as well as to protect the interest of the fund, and to increasingly benefit the interests of the practicing physician.

Your committee feels that this initial venture into what was until recently a new and unexplored field, has resulted on the whole in satisfactory results. It is obvious that we can only function in an advisory capacity, but the fact that we have a medium whereby we may express the ideas of medical groups to the union representatives will go far toward continuing and improving the satisfactory relationship existing at the present time.

Respectfully submitted, *Advisory Committee to the United Mine Workers Welfare and Retirement Fund,* E. P. COLEMAN, M.D., *Chairman,* G. C. OTRICH, M.D., CHARLES O. LANE, M.D., WILLIS I. LEWIS, M.D., B. E. MONTGOMERY, M.D., RALPH S. SABINE, M.D., W. A. MONAGHAN, M.D.

## REPORT OF THE CHAIRMAN OF ADVISORY COMMITTE, STATE COMMISSION ON THE CHRONICALLY ILL

The report of this committee for this year is essentially a repetition of its report last year. There has not been a meeting of the committee at any time because there has been no indication for such meeting. It should be noted that this committee was appointed four years ago when considerable work was done by the State Legislature, through its Commission on the Care of the Chronically Ill. This advisory committee met with them on several occasions in the past, and was instrumental in the production of the report which has been not adopted by the state and yet which, as a report, has been used by other states as a guide in their medical and legislative programs for the care of the chronically ill.

When the commission made its final report to the State Legislature several recommendations were made which had medical significance, but the legislation failed to go through at that particular time. Your committee has been continued because it was thought that the legislature may any time reactivate its own commission or perhaps make recommendations that could be put into law and which would have medical significance. The committee is held over from year to year purely as an advisory committee so as to be in readiness to function in the event that any legislation, either good or adverse, from a medical standpoint might be introduced. As such, it is thought that the committee should be continued for this purpose only.

Respectfully submitted, *Advisory Committee to State Commission on the Chronically Ill,* E. P. COLEMAN, M.D., *Chairman,* F. LEE STONE, M.D., W. W. FULLERTON, M.D., G. E. JOHNSON, M.D., CHARLES ALLISON, M.D.

## REPORT OF THE COMMITTEE ON VENEREAL DISEASE CONTROL

There has been no meeting of the Committee on Venereal Disease Control during the past year due to the fact that we were trying to conserve expenses. The chairman, however, has been in close contact with the Division of Venereal Disease Control through Dr. L. M. Schuman, Chief of the Division, and the report which we are offering consists of two tables, one dealing with morbidity reporting for the calendar year 1949 as compared with the corresponding period of 1948, as well as a table on rapid treatment facility commissions of downstate Illinois patients for the calendar year 1949 as compared with the preceding year.

It will be noted from Table I that there has been a decrease of 14.8% in reported cases of venereal disease in 1949 as compared to 1948. Similar decline in private physician reporting is noted during 1949; syphilis reporting decreasing 27.0% and gonorrhea decreasing 22.6%. However, the ratio of early syphilis (primary, secondary, early latent) reporting to all syphilis reports for both private physicians and other agencies has maintained itself fairly well in this past year with a percentage of 47.6% for 1949 as compared with 52.6% for 1948. A similar relationship for private physician reporting indicates that 42.6% of all syphilis cases were infectious or potentially infectious in 1949 as compared to 43.8% in 1948.

Table II which deals with downstate Illinois cases admitted to rapid treatment facilities at State expense, shows that the total admission loads have fallen from the previous year's level. This was due primarily to the increasing use of penicillin by private physicians and other reporting agencies in the ambulant therapy of syphilis patients. It is still estimated that approximately 50% of all admission to all facilities were referred by private physicians.

For the fiscal year 1949, 212 treatments given by private physicians were at State expense as compared to 368 in fiscal 1948. This was for patients who lived in areas inaccessible to clinics where they would have received indigent care and who could not be hospitalized for various reasons.

The increase in distribution of drugs to private physicians noted in fiscal 1948 has continued in the fiscal year 1949. Penicillin distributions to private physi-

cians has increased considerably in this fiscal year, with a decrease in the distribution of arsenicals and heavy metals. Whereas in the preceding year over 27 billion units of penicillin were distributed to private physicians, public clinics, hospitals and institutions and rapid treatment centers, in fiscal 1949 there was a further increase of 48% for a total of 40 billion units.

Procaine-penicillin was first distributed in this fiscal year. This drug has been distributed to private physicians and other reporting agencies, upon request, for the treatment of cases of early syphilis, syphilitic pregnancies, congenital syphilis (under 10 years of age) and asymptomatic neurosyphilis. It is planned in the next fiscal year, when further evaluation of procaine-penicillin in the treatment of all stages of syphilis has been determined, to supply this drug to private physicians for all such stages of syphilis where effective results have been demonstrated.

Contact investigations by the Illinois Department of Public Health have continued to show improvement for this period over the preceding year. A 3.4% improvement has been noted in total contacts examined though the percentage of cases found infected and treated remained about the same (29%). The improvement (8%) in the examination of contacts elicited from patients of private physicians (8%) contributed greatly to this overall improvement.

In line with the reduction in total number of early infectious and potentially infectious syphilis cases and gonorrhea cases reported, there was a similar decline in the total number of contact referrals and investigations. Thus a reduction in quantity of contact investigations was accompanied by an improvement in quality.

In-service training for personnel of the Division and in the field is an important part of educational work. As opportunities arise, the Division recommends that clinician's nurses and investigators be given the advantage of attending venereal disease courses in various institutions. In this fiscal year, arrangements were made with the Chicago Intensive Treatment Center and the St. Louis Midwestern Medical Center for the in-service training of nurses (staff and supervisors) from the Illinois Health Departments. This training entails a two week comprehensive course in nursing technics, diagnostic procedures and follow-up of rapid treatment cases. Although this plan of training started in April, 1949, 20 nurses* have already attended such courses. This program of in-service training has met with widespread approval and will continue throughout the next fiscal year. Clinicians and health officers are given the opportunity to attend courses at the U. S. Public Health Service Hospital in Hot Springs, Arkansas, on venereal disease control which includes diagnostic procedures, technics of treatment and general control methods. In this fiscal year, 7 clinicians and 4 health officers attended this course.

Special meetings of public health personnel are offered from time to time and provide the opportunity of clarifying procedures and discussing problems common to all. In this fiscal year, three venereal disease institutes dealing with problems of venereal disease diagnosis, treatment, education and control measures were held at LaSalle, Springfield and Mount Vernon.

A case-finding educational program was initiated in Peoria with the cooperation of the U. S. Public Health Service and the Peoria City Health Department. This project developed for the purpose of finding new cases of venereal disease through the education of the public in recognizing or suspecting the early signs and symptoms of syphilis. The project period for this program was from July 1, 1949, to September 30, 1949. Publicity used to familiarize the population with the venereal disease problem included radio broadcasts, newspaper releases, trade pamphlets, lavatory signs, match books, movies and educational materials. A similar program will be instituted in East St. Louis in April, 1950.

Another venereal disease educational project included 10 venereal disease tent shows at county and state fairs during the summer of 1949. Also the venereal disease magazine entitled "My Story" was distributed to all beauty shops in areas where clinics were located in the fall of 1949.

In Table I a comparison of venereal disease reporting for 1948 and 1949 by all reporting sources and private physicians has been made.

39,404 cases of venereal disease were reported to the Illinois Department of Public Health in 1949 as compared to 46,254 in 1948, a decrease of 14.8 per cent. Significant decreases in 1949 were apparent for syphilis (18.2%), gonorrhea (12.5), chancroid (27.7), lymphogranuloma (31.0) and granuloma inguinale (20.4%).

Although the number of reported cases of early syphilis approximates that for the late stages of syphilis, a sharp decline (26.0%) in the reporting of primary, secondary and early latent cases of syphilis is noted in 1949. A small decline is noted for gonorrhea in 1949, although the number of cases (25,080) represents a very high level of reporting in Illinois for this disease.

The overall decrease in reporting of venereal disease by private physicians in 1949 as compared to 1948 was 25.3 per cent. Syphilis cases reported by private physicians in 1949 (6176) and gonorrhea cases (4309) represented sharp decreases from the syphilis and gonorrhea figures in 1948; these differences were 27.0% for syphilis and 22.6% for gonorrhea. In 1948 43.8% of all syphilis cases reported by private physicians were in the infectious and potentially infectious stages; however, in 1949 this percentage decreased to 42.6%, a statistically insignificant diminution in early syphilis case finding.

The rapid treatment program of the Illinois Department of Public Health, utilizing private hospital facilities on a per diem basis, has continued in operation in 1949. Besides agreements with 20 private hospitals in downstate Illinois, downstate patients have access to the two rapid treatment centers in Chicago and St. Louis. A special study of ambulant therapy, which was developed in 1947 in three large health department centers is still being carried on in 1950. Private physicians and venereal disease clinics may refer cases of early syphilis, congenital syphilis and syphilitic preg-

**At this writing, 70 nurses have now availed themselves of this training.*

TABLE I.

REPORTING OF VENEREAL DISEASES BY ALL SOURCES AND BY PRIVATE PHYSICIANS — ILLINOIS — CALENDAR YEARS — 1948-1949.

| *DISEASE AND STAGE* | *NUMBER OF CASES REPORTED* | | | |
|---|---|---|---|---|
| | *TOTAL CASES* | | *PRIVATE PHYSICIANS* | |
| | 1948 | 1949 | 1948 | 1949 |
| SYPHILIS | 17,006 | 13,904 | 8,461 | 6,176 |
| Primary and Secondary | 3,844 | 2,610 | 1,655 | 1,028 |
| Early Latent | 5,108 | 4,015 | 2,047 | 1,605 |
| Late and Late Latent | 7,553 | 6,836 | 4,547 | 3,356 |
| Congenital | 501 | 443 | 212 | 187 |
| GONORRHEA | 28,664 | 25,080 | 5,568 | 4,309 |
| CHANCROID | 343 | 248 | 21 | 10 |
| LYMPHOGRANULOMA VENEREUM | 187 | 129 | 6 | 8 |
| GRANULOMA INGUINALE | 54 | 43 | 5 | 3 |

TABLE II.

DOWNSTATE ILLINOIS CASES ADMITTED TO RAPID TREATMENT FACILITIES FOR THE CALENDAR YEAR 1948-1949.

| Rapid Treatment Facilities | Period | Total Admission | SYPHILIS | | | | | OTHER VENEREAL | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Primary and Secondary | Early Latent | Late and Late Latent | Congenital | Central Nervous System | GONORRHEA | DISEASES |
| Downstate Illinois Hospital Facilities | Jan. to Dec. 1948 | 685 | 340 | 242 | 27 | 33 | 43 | — | — |
| | Jan. to Dec. 1949 | 455 | 193 | 179 | 21 | 22 | 40 | — | — |
| Downstate Illinois Special Ambulant Study | Jan. to Dec. 1948 | 179 | 79 | 75 | 13 | 10 | 2 | — | — |
| | Jan. to Dec. 1949 | 171 | 91 | 45 | 17 | 7 | 11 | — | — |
| Chicago Intensive Treatment Center | Jan. to Dec. 1948 | 298 | 81 | 85 | 27 | 17 | 83 | 2 | 3 |
| | Jan. to Dec. 1949 | 229 | 57 | 71 | 22 | 19 | 55 | 1 | 4 |
| St. Louis Midwestern Medical Center | Jan. to Dec. 1948 | 444 | 185 | 123 | 30 | 14 | 79 | 5 | 8 |
| | Jan. to Dec. 1949 | 413 | 153 | 100 | 56 | 18 | 71 | 10 | 5 |
| All Hospital Facilities | Jan. to Dec. 1948 | 1606 | 685 | 525 | 97 | 74 | 207 | 7 | 11 |
| | Jan. to Dec. 1949 | 1268 | 494 | 395 | 116 | 66 | 177 | 11 | 9 |

nancies, as well as asymptomatic neurosyphilis to these institutions for rapid treatment at State expense.

Table II presents a comparison between the year 1948 and 1949 of the number of downstate Illinois cases admitted to rapid treatment facilities. Total admissions in these facilities decreased in 1949 by 21 per cent. Although this decrease was primarily that of admissions to downstate facilities (33.6%) and the Chicago Intensive Treatment Center (23.2%) slight decreases in admissions were also evident for the ambulant therapy study in Peoria, Rockford, and Decatur clinics (4.5%) and the St. Louis Midwestern Medical Center (7.0%). Early syphilis admissions to rapid treatment facilities in 1949 declined in number by 26.5%, congenital syphilis by 10.8% and central nervous system syphilis by 14.5%.

I. H. NEECE, M.D., *Chairman*, NORRIS J. HECKEL, M.D., HARRY J. DOOLEY, M.D., J. E. WHEELER, M.D., *Committee on Venereal Disease Control.*

## REPORT OF THE ADVISORY COMMITTEE TO THE VETERANS ADMINISTRATION

The contract between the Illinois State Medical Society and the Veterans Administration for the home care of sick and disabled veterans has been renewed without change for a year beginning July 1, 1950.

In recording the figures indicating the extent of this activity, Dr. B. A. Cockrell, chief medical officer for this region of the Veterans Administration, writes:

"The relationship between the Veterans Administration and the members of the Illinois State Medical Society has continued most amicably and has not been marred in any way. I am very appreciative of the manner in which the Illinois State Medical Society, its officers and participating physician members have cooperated with the Veterans Administration and with myself particularly."

The figures available cover the year to February 21, 1950. They show:

| | |
|---|---|
| Veterans examined | 8,358 |
| Total examinations | 16,097 |
| Fees paid | $134,019.11 |
| Average examination | $8.32½ |
| Average per patient | $16.02⅔ |
| Veterans treated | 8,165 |
| Treatments given | 29,385 |
| Fees paid | $138,708.48 |
| Average treatment | $4.72 |
| Average per patient | $17.00 |

The total payment direct to physicians of $272,727.59 does not include additional fees payments through veterans' hospitals for hospitalized patients, which cover some 35,000 of such hospitalization.

The committee also wishes to call to the attention of the House of Delegates that a complete reorganization of the current system of handling these cases is a distinct possibility.

We also must pay tribute to Dr. Cockrell for his cooperative spirit, whatever the inherent deficiencies of this program, and express our appreciation thus formally to him.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman,* F. LEE STONE, M. D., WALTER STEVENSON, M. D., HAROLD M. CAMP, M. D., *Advisory Committee to the Veterans Administration.*

## REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

If you examine the report of the Woman's Auxiliary submitted by the President which is printed elsewhere in this Handbook you will find that they have done an effective piece of public relations work for the State Society this year.

Your Committee has met with them a number of times and has maintained informal contact with them throughout the year. They have been alert to the dangers of compulsory medical care and have encouraged their county units to provide speakers giving this subject and Voluntary Health Insurance widespread discussion.

In the matter of public relations it must be recalled that the Auxiliary has been an effective outlet for much of the material developed by Whitaker and Baxter.

Their organization has been further expanded by the formation of new county groups and also through the use of their "member-at-large" status devised a few years ago for unorganized counties. They have worked for the Benevolence Fund and have continued their interest in searching for historical data of a medical nature which will be helpful in the new volume, "The History of Medical Practice in Illinois."

Activities of our Auxiliary has brought national recognition to Illinois in several instances. For instance the Illinois Auxiliary was a pioneer in establishing schools of instruction for its membership wherein their members would receive instruction in the objectives of the Auxiliary, the duties of its officers, and parliamentary procedure. It is now planned to adopt this on a national scale.

Due to its activity no doubt, Illinois has been chosen as the hostess group this year for the National Conference of State Auxiliary Presidents and Presidents-Elect. This conference is held in the fall each year and our Illinois Auxiliary is justly proud of bringing recognition to our State. And finally the President of our Auxiliary, Mrs. Egan, has been asked to give the response to the Address of Welcome by the National Auxiliary this coming June in San Francisco.

Your Advisory Committee commends the Auxiliary to your attention. In many ways too numerous to mention in a brief report, its activities are helpful to the State Society and they certainly deserve our thanks, our support and our good wishes.

Respectfully submitted, DARWIN B. POND, M.D., *Chairman,* H. KENNETH SCATLIFF, M.D., *Co-Chairman,* W. C. BORNEMEIER, M.D., E. G. BEATTY, M.D., HAROLD M. CAMP, M.D., *Advisory Committee to The Woman's Auxiliary.*

DR. H. K. SCATLIFF, Chicago: I have a supplementary report. This is some additional information that has come to us since the report was printed in the Handbook. It has to do with the activities of the Woman's Auxiliary:

All the officers of the Auxiliary have attended the speaker's training course, and as a result they are anxious to join in supporting you in a fight against socialized medicine, and ask to be guided in that aid. This is in addition to their activities already carried on such as the support of the Benevolence Committee to which they have contributed $5,354 the past year. They have promoted the sales of "Today's Health", formerly "Hygeia" to the extent of 560 subscriptions. They have been active in collecting historical data for the Society.

THE PRESIDENT: That shows that the Woman's Auxiliary is doing a wonderful work for the doctors.

## REPORT OF COMMITTEE ON CANCER CONTROL

The annual death rate from cancer continues to increase in spite of improvements in methods of diagnosis and treatment. This disease ranks second to heart disease as a cause of death in the United States. A recent report of a large life insurance company reveals that in 1949, 16.5 per cent of deaths were due to cancer compared to 13.6 per cent in 1945. Deaths from heart disease constituted 44 per cent of deaths in 1949 compared to 24 per cent in 1945. The death rate of practically all other diseases decreased during this period.

During the past year a new test for cancer has been developed by Dr. Charles Huggins, of Chicago. Much more time will be needed for determination of the exact value of this test, although in certain respects it has already proven to be of distinct aid, though by no means infallible.

Of the State agencies conducting activities in the fight against cancer, the Illinois Division of the American Cancer Society, and the Division of Cancer Control, Department of Public Health have been most active.

Dr. John Rogers is the Executive Director of, and Mr. Edward Wilson, President of the Illinois Division of the American Cancer Society. Dr. Rogers has kindly furnished data as listed below representing activities of the Division.

The program of professional education for the Division has been continued with marked success. Two five-day refresher courses were held during 1949; attended by about 100 physicians, most of whom were from downstate. This program was conducted at the Northwestern University Medical School, the University of Illinois College of Medicine, the Loyola University School of Medicine (Mercy Hospital), the University of Chicago School of Medicine and Michael Reese Hospital. It is believed that this course is unique in the country since it provides expert instruction in the early diagnosis and treatment of cancer in every part of the body. These courses are sponsored in cooperation with the Illinois State Medical Society.

The program of public education is for the purpose of alerting men and women to the danger signs of cancer and the imperative necessity for immediate treatment. During the past year, over a million pieces of literature have been distributed. Exhibits have been conducted at forty-two county fairs and the state fair. An educational film has been shown 3,390 times—educational service has been given 2,065 industries. The monthly publication, "Illinois Cancer News," now has a mailing list of nearly 21,000.

The service program of the Illinois Division may be divided into lay and professional activities. It operates twenty cancer information centers within the state which provide counseling service to individuals seeking help about a personal or family cancer problem. No medical advice is given but these offices manned by trained personnel, are extremely valuable in organizing local educational efforts and coordinating our other activities.

The Division has continued to support cancer detection centers located at Women's and Children's, Grant and Mercy Hospitals. The detection center at Henrotin Hospital has been discontinued but the professional personnel has continued to do this work at the Cancer Prevention Center of Chicago, Inc., located at 17 West Huron Street. Considerable progress has been made in furthering the plan, "every Doctor's Office a Cancer Detection Center," which has been approved in principle by the Illinois State Medical Society.

The cancer exhibit at the Museum of Science and Industry, which was planned and constructed under the supervision of Professor Tom Jones at the University of Illinois, was opened in April, 1949. This represented an expenditure of $50,000. The importance of this exhibit as a means of public education is attested by the fact that it has been visited by over 200,000 people and that our educational film has been shown to over 32,000 of these visitors.

The Illinois Division has provide assistance in Visiting Nurse Associations for visits to deserving cancer patients in Rockford, Elgin, Chicago, Aurora, LaSalle, Ottawa, Marseilles, Peoria, Alton, Joliet, Decatur, Evanston, Berwyn-Cicero, Vermilion County, and Sangamon County. A $6,000 grant was made to the Social Service Department, Cook County Hospital, to provide social workers for the breast and gynecological clinics. Financial assistance has been given to the cancer clinics at Norwegian American Hospital, St. Bernard's Hospital, St. Luke's Hospital, Mercy Hospital, Ravenswood Hospital and Northwestern University Department of Gynecology and Obstetrics, in Chicago; Herrin Hospital, Herrin; St. Anthony's Hospital, Rockford; Northwestern University Department of Surgery, Chicago; Little Company of Mary Hospital, Evergreen Park; Sherman Hospital, Elgin; Burnham City Hospital, Champaign.

A year's subscription to The Cancer Bulletin has been provided gratuitously to the more than six thousand members of the Chicago Medical Society. The Cancer Control Division of the Illinois State Department of Public Health has provided a year's subscription to this bulletin for all other physicians in the state.

The campaign for funds in 1949 totaled $743,562. Forty per cent or $297,724 was sent to the national organization. During the year, research grants in the amount of $323,219 were awarded for various projects in Illinois. These were distributed to the University of Illinois, Northwestern University, University of Chicago, Michael Reese Hospital, Chicago Medical School and a small amount to Herrin Hospital, Herrin, Illinois.

Dr. G. Howard Gowen is Chief of the Division of Cancer Control of the Department of Public Health for Illinois. He has kindly submitted data given below, representing a summary of their activities.

The number of State-aided cancer clinics has been increased from 20 to 22. The new clinics are located at St. Joseph's Hospital, Joliet and Good Samaritan Hospital, Mount Vernon. The amount expended in support of these clinics during 1949 was $136,301.15. The following figures indicate the amount of clinical activity:

| | |
|---|---|
| Physicians attending | 8,237 |
| New Patients examined | 4,577 |
| Tissues examined from Medically Indigent Patients | 2,809 |
| Proved Malignancies Reported | 1,623 |

"In order to stimulate the performance of autopsies on persons dying from cancer we have been paying a fee of $25 to pathologists performing such autopsies on individuals whose families were in poor financial circumstances. During the past year 10 such autopsies were performed."

"During the past year we have sent two of the pathologists and one technician from our State-aided cancer clinic to take the course in exfoliative cytology given by Dr. Papanicolaou of Cornell University and one pathologist to take the course in hematologic diagnosis at Michael Reese Hospital in Chicago."

"In cooperation with our Division of Public Health Dentistry two symposia on oral cancer for dentists were held; one of these was at Herrin and the other one at Canton."

"The results of our survey of downstate deep x-ray facilities was published in the Illinois Medical Journal, December, 1949. The results of our study of the value of the tuberculosis chest survey as a medium for the early diagnosis of neoplasms of the chest is now on press, and will appear shortly in the Illinois Medical Journal."

"We carried on a cooperative program with the Illinois Division, American Cancer Society in the distribution of The Cancer Bulletin to all physicians in the State of Illinois."

"Films on Cancer—the Problems of Early Diagnosis, and Breast Cancer—The Problem of Early Diagnosis, were purchased for each of the following medical schools to aid them in their teaching programs: Loyola University, Chicago Medical School, and the University of Illinois. Also, one copy of each of the films was added to our film library for use by county medical societies. Three new lay educational pamphlets were published entitled, Cancer of the Lung, Cancer of the Large Bowel and Rectum, and Your Future."

Respectfully submitted, WARREN H. COLE, M. D., *Chairman,* H. E. DAVIS, M. D., ROSWELL T. PETTIT, M. D., THOMAS C. GALLOWAY, M. D., EDWIN F. HIRSCH, M. D., CHARLES L. LEONARD, M. D., *Committee on Cancer Control.*

## REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

The Constitution and By-Laws Committee has had two matters offered for consideration during the past year:

(1) Clarification of the membership situation in the county society and the Illinois State Medical Society in relation to the American Medical Association, and,

(2) Provision for a Grievance Committee of the Illinois State Medical Society.

Both of these matters have been studied and the Constitution and By-Laws Committee recommends for your approval the following amendments:

1. To clarify membership.

Amend Article III of the Constitution by adding: Members of component societies shall be members of this organization and of the American Medical Association.

Amend Article X of the Constitution by adding to the end of Paragraph 1: Such assessment shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

Amend Chapter XI, Section 1 of the By-Laws by adding: , and members thereof shall become members of this society and of the American Medical Association.

2. To set up a Grievance Committee.

Amend Chapter IX, Section 1 of the By-Laws by adding: A Grievance Committee.

Amend Chapter IX by adding Section VIII. The Grievance Committee shall consist of six members, two of whom shall be elected each year by the House of Delegates to serve for a term of three years. At the first election held under this By-Law, two members shall be elected to serve one year, two for two years and two for three years.

The functions of the Grievance Committee shall be: (1) to cooperate with the Grievance Committees of component societies, where such committees exist, in the effort to adjust differences between members of the Society and the public. (2) to act for the Society in investigating complaints and/or initiating investigations concerning professional conduct and ethical deportment, in those counties which do not have a Grievance Committee.

In conducting such hearings at least two members of the committee shall be assigned to conduct impartial, secret hearings. At such hearings members of the Society may be ordered to appear and lay complainants may be invited to appear, if deemed necessary.

The investigating members should attempt, through advice and counsel, to settle minor complaints and differences of opinion, in the interest of improved public relations. If in the opinion of the investigators, fees have been excessive, they may suggest that the offending physician make some satisfactory adjustment, and may warn the individual that repetition of the offense may result in disciplinary prosecution with the Society.

If, after full investigation, the committee feels that evidence warrants, it may prefer charges of unprofessional conduct against the offender before the Ethical Relations Committee of the component Society to which he belongs.

(3) The committee does not have the power to try a member or to impose discipline. It can investigate; it can advise; and it can prosecute.

(4) The committee shall report to the House of Delegates at the annual meeting.

Respectfully submitted, WARREN W. FUREY, M. D., *Chairman,* FRED H. DECKER, M. D., PLINY R. BLODGETT, M. D., *Committee on Constitution and By-Laws.*

DR. WARREN FUREY: I have a supplementary report. The report of the Committee on Constitution and By-Laws is on page 57 of the Handbook. We have found that there is a difference between our By-Laws and the By-Laws of the American Medical Association as to the time at which delinquents in dues shall be dropped. Our By-Laws state that any member in arrears shall be dropped automatically on December 31. The A.M.A. says that if a member fails to pay his dues within 30 days after notice of his delinquency he will then be dropped. It is recommended by the Committee on Constitution and By-Laws that we amend Chapter 2 of our By-Laws to correspond to the By-Laws of the A.M.A. (The supplementary report was referred by the president to the reference committee.)

## REPORT OF THE COMMITTEE ON CRIPPLED CHILDREN'S CLINICS

Crippled Children's Clinics in Illinois are well organized, well publicized, and are functioning satisfactorily. The great majority of clinics have hospital con-

nections so that operative treatment can be carried out promptly.

Those throughout the State are conducted by several agencies, the principal ones being:

1. The Illinois Elks Crippled Children's Committee.

2. Division of Services for Crippled Children, University of Illinois, under the supervision of Dr. Herbert R. Kobes.

3. A number of independent Crippled Children's Clinics sponsored by individual County Medical Societies.

The Elks Association:

Clinics Held—1949 ..... 150
Total examinations ..... 2,553
Number of cases hospitalized ..... 169
Number of hospitals used ..... 9

Division for Crippled Children, University of Illinois, under the supervision of Dr. Herbert R. Kobes, includes the following:

| *Site of Clinic* | *No. of Clinics* | *Average at each Clinic* |
|---|---|---|
| Peoria | 24 | 69 |
| East St. Louis | 14 | 58 |
| Hinsdale | 11 | 53 |
| Rockford | 11 | 52 |
| Normal | 12 | 34 |
| Alton | 6 | 51 |
| Chicago Heights | 6 | 47 |
| Joliet | 6 | 46 |
| Sterling | 5 | 53 |
| Cairo | 4 | 55 |
| Danville | 4 | 50 |
| Quincy | 3 | 64 |
| Litchfield | 3 | 55 |
| Springfield | 6 | 27 |
| Shelbyville | 2 | 74 |
| Fairfield | 2 | 70 |
| Macomb | 3 | 47 |
| Evergreen Park | 4 | 35 |
| Mt. Vernon | 2 | 63 |
| Salem | 2 | 62 |
| Clinton | 2 | 58 |
| Casey | 2 | 57 |
| Centralia Polio | 2 | 55 |
| DuQuoin | 2 | 54 |
| Centralia | 2 | 50 |
| Glenview | 3 | 31 |
| Elgin | 3 | 30 |
| Watseka | 3 | 30 |
| Jacksonville | 2 | 44 |
| Aurora | 3 | 29 |
| Carrollton | 2 | 40 |
| Shawneetown | 1 | 68 |
| Pittsfield | 2 | 60 |
| Flora | 1 | 63 |
| Golconda | 1 | 62 |
| Chester | 1 | 55 |
| Metropolis | 1 | 52 |
| Monticello | 1 | 52 |
| Effingham | 1 | 47 |
| Vandalia | 1 | 38 |
| Anna | 1 | 25 |

Crippled Children's Clinics held in Chicago and suburbs in Cook County:

*Chicago Group.* Medical Schools and Hospitals.

*University of Illinois.* Out patient Orthopædic Department:

Clinics: 10 per week.

10,123 patients treated during 1949. Of this number approximately 70% were children.

*Loyola Medical School.* Clinics given at Mercy Hospital.

Clinics: 1 per week for children. 2 per month for spastic cases.

*Northwestern University Medical School.* Montgomery-Ward Clinic.

Clinics: 4 per week for children.

*Chicago Medical School.* In connection with Mt. Sinai Hospital.

Clinics: 2 per week. A small percentage of these are orthopædic cases.

*University of Chicago.* Bobs-Roberts Memorial Hospital for Children.

Clinics: 6 per week.

Approximate number of children's visits—1,367.

*St. Luke's Hospital.*

Clinics: 4 per week.

Approximate number of children per week—36.

*Michael Reese Hospital.* Mandel Clinic

Clinics: 2 per week. Cerebral palsy clinic—211 visits.

Patients treated—424. Total clinical visits—1,214.

*Presbyterian Hospital.* Central Free Dispensary

Clinics: 2 per week.

Average patients per clinic—48. Clinical visits—153.

*Provident Hospital.*

Clinics: 4 per month.

An average of 70 cases treated at each clinic.

*Shriners Hospital.*

Clinics: 100 per year.

Clinical visits—1,939.

*Children's Memorial Hospital.*

Clinics: 2 per week.

An average of 339 patients treated.

*Cook County Hospital.*

Clinics: 6 per week.

1,421 patients treated during 1949.

Cook County Department of Public Health.

This department conducts several Physical Therapy Treatment Clinics in Cook County, outside of Chicago. Locations are:

1. Berwyn—1 clinic per week.
2. Des Plaines—1 clinic per week.
3. Harvey—1 clinic per week.
4. Chicago Heights—1 clinic per week.
5. Maywood—1 clinic per week.
6. Evergreen Park—1 clinic per week.

Clinical and conference visits—513.

Field and office visits—1,445.

Physiotherapy treatments—1,865.

CONCLUSIONS—In Chicago Crippled Children's Clinics are adequate, both as to number and hospitaliza-

tion facilities, to give proper treatment to the present number of crippled children.

Downstate clinics are held from one to four times a year. Throughout the State, clinics are held in most of the counties. The locations of the clinics are such that it is convenient for almost all of the crippled children to be brought to the clinics regularly.

Respectfully submitted, FRANK G. MURPHY, M. D., *Chairman,* RALPH P. PEAIRS, M. D., CHARLES PAPIK, M. D., HERBERT R. KOBES, M. D., GERARD N. KROST, M. D., *Committee on Crippled Children's Clinics.*

## REPORT OF THE EDUCATIONAL COMMITTEE

The following report, covering the activities of the Educational Committee, is submitted as evidence that the Committee is fulfilling the objective for which it was created in 1922: the dissemination of practical and sound information on health education to the public.

It is obviously impossible in any report to describe in detail or even enumerate all the activities of this committee. The entire time of the Secretary, Miss Ann Fox, is given to this work and with her in the office at 30 North Michigan, there are two full time stenographers and a mailing clerk working one-half time. This force has carried on devotedly and well, but, their full services have been taxed this year in the production of the Educational work. To continue the projects now being pursued will in the very near future require additional facilities.

TELEVISION—In April, 1950, the Committee marked its fourteenth month of providing health education over WGN-TV. Since the last annual report the following telecasts have been offered:

May 10, 1949 Charles D. Krause, So You're Expecting a Baby.
May 17, Maurice H. Cottle and Lee Hoyt, If Your Nose Needs Repair.
May 24, Howard B. Carroll, Peptic Ulcer.
May 31, Warren W. Furey, The Story of X-Ray.
June 7, Gilbert H. Marquardt, Geriatrics and You.
June 14, Robert G. Kesel, D. D. S., Douglas W. Kerr, D. D. S., Your Child's Dental Health.
June 21, Samuel M. Feinberg, Hay Fever.
June 28, Philip Thorek, Goiter.
July 8, George E. Shambaugh, Jr., Your Child's Hearing.
July 15, L. Martin Hardy, Understanding the New Baby.
July 20, Louis Scheman, Footsteps to Health.
July 27, Walter Mayne, Surgical Repair of the Face.
August 3, Louis R. Limarzi and Paul L. Bedinger, The Story of Blood.
August 10, Max S. Sadove and James H. Cross, Guardians of Your Sleep.
August 17, Samuel G. Plice and Carl Pfister, How's Your Blood Pressure.
August 24, Morris Friedell and Fenton Schnaffner, Radioactive Research in Medicine.
August 31, (program postponed).
September 7, George Wiltrakis, Richard Graff, The Old Look in Mental Care.
September 14, Louis B. Newman and H. Worley Kendall, Building a New Life.
September 21, (postponed because of baseball events).
September 28, (postponed because of baseball events).
October 5, Robert S. Berghoff, What Is Heart Disease?
October 12, Coye C. Mason, What is Pathology?
October 19, Paul A. Campbell, Dizziness.
October 26, Paul H. Holinger, Peanuts, Pennies and Safety Pins.
November 2, Danely P. Slaughter, Maybe It Is Cancer.
November 9, Evan Barton and Samuel J. Hoffman, What's New in Arthritis.
November 16, Mr. Tom Jones, Visual Health Education.
November 23, Louise Tavs, Cosmetics and You.
November 30, John A. Mart, So You've Had a Heart Attack.
December 7, James J. Callahan, So You've Broken a Hip.
December 14, Clayton G. Loosli, The Common Cold.
December 21, Herman N, Bundesen, Care of the Premature Infant.
December 28, Harvey S. Allen, Burns.
January 4, 1950, Eugene T. McEnery, Getting Ready for School.
January 11, Andy Hall, Harold M. Camp, H. Kenneth Scatliff, Leo Zimmerman, Walter Priest, Jacques Smith, Benjamin Rappaport, Hobbies for Health.
January 18, Claude Lambert and Pearl Wittmark, R. N., Applying a Cast.
January 25, Percy E. Hopkins, Miss Lita Abele, R. N., Inside the Operating Room.
February 1, Wayne B. Slaughter, Plastic Surgery of Your Growing Child.
February 8, Maury Massler, D. D. S., Your Child Goes to the Dentist.
February 15, Lawrence Breslow, The Second Child Arrives.
February 22, Walter H. Theobald, Mr. E. Todd Wheeler and Mr. George McLester, Chicago's Medical Tomorrow.
February 28, George L. Apfelbach, Roland Lippold and Samuel J. Hoffman, Injuries Commonly Overlooked.
March 7, George V. Byfield, Howard J. Shaughnessy, Ph. D., Undulant Fever.
March 14, Leo Kaplan, What Is Neurology.
March 21, George E. Park, Mr. Alfred Schmieding, Reading Difficulties in Children.
March 28, Carroll L. Birch, Small Game Hunting in Africa.

The weekly series on television is called *Health Talk,* linking it with the weekly story, called *Health Talk,* for the press and monthly to the laity. With the exception of eight telecasts, Dr. Theodore R. VanDellen, Assistant Dean, Northwestern University Medical School, and Medical Editor of the Chicago Tribune, has acted most efficiently as moderator, in keeping with the Committee's opinion that only a medical moderator carries on the fluidity required in medical dialogue. It is expected that the television scripts will be copyrighted beginning May first.

That Health Talk via television has met with unusual interest and success is reflected in Jack Mabley's column in the Chicago Daily News, December 2, when Health Talk was cited as one of the outstanding programs on the air. In the first poll of televiewers and subscribers to Television Forecast, TV's weekly bulletin of programming, Health Talk was selected as one of the five best educational telecasts emanating from Chicago.

Publicity and press coverage has been excellent in not only the metropolitan newspapers of Chicago, but in the JAMA, Bulletin of the Chicago Medical Society, and faculty bulletins of the five medical schools of Chicago. Articles on the series have appeared in Television Forecast, Medical Economics, and the program has been listed under "Special Events" in the day's listing in the Chicago Tribune.

Significant impetus and recognition to the series was given in an editorial in the Illinois Medical Journal marking the first year's anniversary and written by Harold M. Camp, Secretary of the Illinois State Medical Society. Other outlets of publicity have included Channels, the national publication of health and welfare agencies, the Welfare Bulletin of the State Department of Public Welfare, the Newsletter of the American Society of Anesthesiologists.

Congratulatory letters for implementing televised health education were received from Andrew C. Ivy, Mr. Tom Jones, both of the University of Illinois.

The Chicago Dental Society was so pleased with the programming of "Your Child Goes to the Dentist" during its annual meeting that it financed the moving of equipment into the studio and installed television sets throughout the Stevens Hotel. Formal recognition to the telecast program was given in the program of the Chicago Dental Society and its Fortnightly Review.

Spencer Allen, commentator for WGN and WGN-TV, devoted most of his paper before the breakfast for hospital and press representatives during the session of the American College of Surgeons in October to the activities of the Educational Committee via television.

It is significant that the first fluoroscopic demonstration ever attempted for public televiewing was developed in this telecast, and was made possible through the cooperation of Standard X-Ray Company, the Cambridge Instrument Company, and engineers of WGN-TV. This telecast has attracted requests from General Electric Company, other state medical associations, tuberculosis and heart associations throughout the country, and Harvard University School of Public Health.

The Committee wishes to acknowledge formally to the House of Delegates the cooperation of the following companies in providing equipment for various telecasts: Ohio Chemical and Manufacturing Company, Abbott Laboratories, Cambridge Instrument Company, Sanborn Company, Picker X-Ray, Audio Development Company, Central Scientific Company, Nuclear Instrument and Chemical Company, Zimmer Splint Company, Standard X-Ray Company, William Ballert and Company, V. Mueller and Company, Continental Scale Company, and Sportsman's Club of America. Credit should go to the medical schools of Chicago for their splendid cooperation. WGN-TV is accorded special recognition for its interest, assignment of time and constructive criticism.

The Public Relations Department of the A. M. A. asked for and received an outline of the television experiences of the Committee, which was released in the March PR Doctor, together with a sample script.

Dr. W. W. Bauer, Editor of Today's Health, asked for a picture spread to use in a forthcoming issue.

The Educational Committee was invited to present a telecast at the Institute for Education by Radio, sponsored by the Ohio State University, marking the first time that the Ohio State Medical Association assumed the development of the health workshop of the institute and the first time that television has been given a formal part in the institute. The Committee selected "Guardians of Your Sleep" as the telecast to mark the pioneer effort. Abbott Laboratories assumed the financial expense for transporting the "cast" to Columbus, and the Columbus dealers of the Ohio Chemical Company, Columbus Hospital Supply Co., and the Wendt-Bristol Co., cooperated in providing equipment. WGN-TV cooperated in obtaining local outlets as well as making available studio experience in projecting this telecast, about which Larry Wolters said in the Tribune: "For sheer drama this far outstripped any video whodunit."

In the Mail: "I have had the privilege of being able to view and listen to your very interesting and educational program. I sincerely appreciate this fashion of program and hope to see yours and more like it in the future."—New Lenox, Illinois.

"I heard your program on WGN-TV this aftenoon on undulant fever. I have this and most likely got it through handling cattle or handling the meat, for that is my work as you can see from this letterhead. The way you explained it is my case to the T. May I have more information?"—Baroda, Michigan.

SPEAKER'S BUREAU—As of April 1, 1950, 144 speakers had been scheduled as against 146 for the previous year. Of this total fifteen are for dates beyond the year covered by this report. One was for a telecast on euthanasia, over WGN-TV, one on the bill of medical education, also a telecast over WGN-TV, and one a radio talk on euthanasia on the Sun-Times series over WJJD, "Let's Talk It Over." Two speaking postponements were cancelled.

Other organizations serviced include various ones from all portions of the state. Our reports from listeners and from the speakers are quite uniformly encouraging.

Seven speakers were scheduled on "Medicine as a Career" in the second Career Conference, sponsored by the Sun-Times, the Chicago Technical Societies and the Illinois Institute of Technology.

Sixteen speakers were scheduled in the Youth Week series sponsored jointly by the Chicago Medical Society and the Chicago Board of Education.

Physicians who cooperated in the Speakers' Bureau, sometimes accepting two and more invitations, are: Marc Hollender, Norman T. Welford, Marie Wessels, Frank Deneen, Harlan English, John T. Reynolds,

Walter Stevenson, Louis River, Charles J. Runner, John A. Rogers, James H. Hutton, Murray Nierman, William B. Raycraft, Walter R. Kirschbaum, Carroll Stuart, Joseph Bertucci, R. E. Davies, Robert Hagan, Lawrence Breslow, Robert E. Cummings, W. W. Bolton, Alfred D. Biggs, Robert E. Lee, Harry Leichenger, S. Sinclair Snider, Paul K. Anthony, Eugene T. McEnery, Franklin Corper, Arthur Rosenblum, Leo Kaplan, George V. LeRoy, Florence M. Rees, David Slight, Warren H. Cole, J. Charles McMillan, Jr., John L. Reichert, Edward J. Brophy, Adrian D. M. Kraus, Elmer E. Swanson, Edwin F. Hirsch, I. Michael Levin, Rex D. Hammond, Bertha Shafer, Philip B. Marquardt, Ralph Hamill, Robert Mustell, Joan Fleming, Stanley C. Stanmar, Irving Steck, George A. Waltrakis, P. V. Dilts, Harry J. Dooley, Joseph T. O'Neill, Theodore R. Van Dellen, Harry M. Hedge, George M. Cummins, Donald A. Dukelow, Alex J. Arieff, Rudolph, Novick, Edwin R. Levine, Winston H. Tucker, Edward A. Piszczek, Hugh A. Flack, Richard Young, John J. Sheinin, Donald G. Anderson, Wright Adams, Y. T. Oester, F. Garm Norbury, George Hellmuth, Herbert McMahan, Carl H. Hamann, Charles W. Scruggs, Herbert E. Schmitz, Ernest W. Gutzmer, Groves B. Smith, Carl W. Christensen, Frederic T. Jung, George J. Kidera, Robert M. Kark, Harold M. Camp, Jules Masserman, Israel Davidsohn, Julius E. Ginsberg, Morley McNeal, Israel Sonenthal, Paul H. Wosika, Ford K. Hick, Morris Braude, Arlington Ailes, B. J. Canfield, Paul L. Ermer, and A. H. Wolff.

In addition the following laymen cooperated: Mr. Ben Park, Mr. Robert Krit, Mr. Joseph McLary, Mr. Louis deBoer, Mr. Oliver Field, and Mrs. Kris Peterson.

HEALTH TALK—As of March 15, the weekly mailing list for *Health Talk* was 903 as compared with 894 on March 15, 1949. Every effort is being made to restrict the weekly list to newspapers, key people concerned with education, state medical societies and science writers. As of March 15, the monthly list was 3952 as compared with 3970 a year ago. During the year 250 new names were added to the list, but the difference is noted because of the return envelopes marked "moved or deceased." In addition, 15 persons are receiving 795 copies as compared with 10 persons who received 527 copies in March, 1949.

With the use of the return postage guaranteed envelope, launched two years ago, it is now possible to weed out all changes of address out of the state and deaths. Thus it is safe to say that the current weekly and monthly mailing lists are active. If a close check were not made of the mailing, it would be difficult to restrict growth to the limits of clerical and economical proportions.

The actual count of papers using *Health Talk* regularly is 315 as compared with 222 listed in 1949. Because of the inaccurate coverage of the press clipping bureau, a total of 350 is safe to assume.

Random comments on *Health Talk* are as follows:

From Templeton, Kenly & Co.: I have seen your bulletin *"Health Talk"* on various occasions and was impressed and pleased with both the subjects and the method of presentation. Are these pamphlets available for distribution to our company to post on our bulletin boards? I believe they would be read with great interest by our employees.

United Specialties Company: The industrial nurse was responsible for thirteen industries throughout the state being placed on the mailing list: Illinois Meat Company, Public Service Company of Maywood, Commonwealth Edison Company, International Harvester Company, Peoples Gas Co., Chicago Steel Foundry, Interstate Bakeries, the Chicago Sun-Times and Continental Can Company. Station WMBI asked for issues to incorporate in its program "For Better Health."

With some 1,000 schools on the monthly list, it is interesting that many requests were received during the past year, among them Union High School in Chester, Peoria High School, Bloomington High School.

While each issue receives good press coverage, certain issues meet an unusual response. "Try Laughing" was given widespread coverage in all the newspapers and wire services. with the metropolitan papers of Chicago covering it editorially and with picture features. This issue was submitted in the contest sponsored by the Illinois Women's Press Association.

"Physical Education" brought comments from many educators and in particular the following: Ray O. Duncan, State Director of Health, Physical Education and Safety: " . . . Articles of this type do more than anything else to interpret to parents the meaning of a modern program of physical education, and I certainly want to commend the Illinois State Medical Society for this article." From Fred Hein, Ph. D., Consultant in Health and Physical Fitness, AMA: "May I take this opportunity to compliment you and the others responsible for the excellent statement of the Illinois State Medical Society on school physical education which has lately had wide publicity in Illinois newspapers. Recently at an educational conference I heard some very favorable comments about the material from some of the leading educators in the state. This material had unquestionably a worthwhile educational influence.

"Coffee with the Kelseys," a popular fifteen minute program over WGN, uses certain issues of *Health Talk* carrying full credit to the Educational Committee.

Blueprint for Health featured "Tetanus or the Myth of the Rusty Nail" with illustrations.

From Philip Lewin: I received the *Health Talk* entitled "Understanding ACTH" which arrived this morning. I hasten to congratulate you and the members of the Educational Committee for a very fine exposition on this subject.

Jane Stafford, Science News Service, uses certain issues of *Health Talk* in her sydicated column. The Howard Cabinet, Los Angeles, in a letter accompanied with a photostatic copy of the Stafford story on the issue "Cosmetics and You," asked for permission to reprint it. The request was denied because of the commercial implication. The American Foot Care Institute, Inc., New York, in a similar fashion, asked for the *Health Talk* titled "Athlete's Foot."

Two state medical societies, New Hampshire and North Carolina, were inadvertently removed from the

mailing list. Letters were received asking to be reinstated. Santa Clara County (Calif.) Medical Society asked to be added to the list.

Two issues of *Health Talk* were given mention in Hygeia. The Illinois Agricultural Association asked for 112 copies each of "Slump, Strain and Suffer," "Tuberculosis—A Year Round Disease," "Try Laughing," "Keep Yourself Clean," "Baldness," and "Health Aspects of Television." The Illinois Society for Mental Hygiene, 1500 of the issue "Growing With Your Child," and various issues of 15 to 400 to distribute at round-ups and other health meetings.

From Br. Sebastian Kuhn, St. Procopius Abbey, Lisle, Illinois: The *Health Talk* entitled "Treatment of Warts" has, I'm glad to tell you, proved interesting to all of us at this Abbey and College. Of more direct interest to me, however, would be your issue on "Epilepsy." Will you kindly send it to me?

From Springfield High School: I am wondering how much seventy-five copies of your *Health Talk* "Help Your Mind Help You" will cost us. It seems to me that this little health talk would be quite valuable to put in the hands of each of our faculty members.

From Hospital Nursing Consultant, Department of Public Welfare, Springfield: Thank you for the fifteen copies of *Health Talk* "Mental Health of the Child." It is material such as this that is valuable to us in connection with our program of in-service training attendants in the state institutions. Many of the new attendants have no concept of what is required in the care of the whole child, having in mind only the physical well-being of the individual, and many times a limited knowledge of what that embraces. We might tell them over and over the attitude to assume, but the printed articles such as this makes them realize that others are thinking along the same lines and eventually it begins to dawn on them that there is a science to the care of these little unfortunate patients.

RADIO—A series of radio transcriptions was launched over FM Station WFJL, February 2. Initiated by a steering committee without clearance from the Chicago Medical Society or the Educational Committee, the work has been taken over by the latter to coordinate activities and supervise script material: Letters of invitation go to the physician announcing the date of the transcription and setting the date for the script to be in the Committee's office. Copies are then sent to members of the Committee for editing and suggestions. Appointments are then set up for the participating physicians with the station to cut the platter.

Thus far the following physicians have participated:

Gilbert H. Marquardt, February 2, "Why Bother About Health."

William J. Pickett, February 9, "Surgical Trends in the Last Generation."

Charles I. Fisher, February 16, "Is Your Blood Pressure Misbehaving?"

Kenneth I. Roper, February 23, "Eye Care in Adolescence."

Arnold I. Schimberg, March 2, "Colitis."

George M. Cummins, March 9, "Ulcers."

H. Kenneth Scatliff, March 16, "Mental and Physical Fitness in the Home."

Robert S. Berghoff, March 23, "Heart Disease After Middle Age."

Marc H. Hollender, March 30, "Emotional Needs of Older People."

Morris Fishbein, April 6, "Quacks and Quackery."

A similar series was to be launched over WCFL, under the direction of Dr. James P. Shortall, in cooperation with the Chicago Federation of Labor. Thus far, definite steps have not been developed, although the Educational Committee expressed its cooperation.

To March 15, 1950, 69 package libraries were mailed.

With the expanded activities, the Secretary has found it increasingly difficult to attend as many meetings of allied groups as she would like. However, she addressed the Park Manor Woman's Club, the South Side Branch and the North Side Branch of the Woman's Auxiliaries to the Chicago Medical Society, and participated in the AMA PR Session, "Get It Off Your Chest." She also addressed the health session of the Illinois Congress of Parents and Teachers, and attended some meetings if the Council on Social Agencies, the Publicity Club, Illinois Woman's Press Association, Illinois Social Hygiene League, Woman's Auxiliary to the Chicago Medical Society, Press and Hospital Representatives Breakfast of the American College of Surgeons.

Routine activities include the preparation of The News of The State pages of the *Illinois Medical Journal,* the obituaries, the Column for "The Common Good," the publicity in the Bulletin of the Chicago Medical Society, the *JAMA,* and faculty bulletins of the medical schools of Chicago, as well as press publicity for other committees for which the Secretary is responsible.

The Committee wishes to emphasize again that this report is but an outline of accomplishments and in no way a yardstick of the time spent in projecting and fulfilling its obligations. Through its various facets, the Committee presents the Illinois State Medical Society to the public and its own members at a minimum average of four times a week.

The Committee wishes to express its appreciation to the House of Delegates and the Council of the Illinois State Medical Society for their confidence. With this official sanction, the Committee has endeavored to broaden its educational scope for good health and to reflect the integrity of the medical profession. In conclusion it directs attention to the singular efficiency and cooperation that exists between the executive lay personnel identified with all activities, Mrs. Frances Zimmer, Mr. John Neal, Mr. L. E. Malley, and Mr. James Leary, and commends the satisfactory work of the staffs of the Chicago and Monmouth offices. And especially the Committee wishes to express its appreciation of the fine cooperation accorded it by the officers and office personnel of the Chicago Medical Society.

Respectfully submitted, CHARLES P. BLAIR, M. D., *Chairman,* FORD K. HICK, M. D., *Vice Chairman,* GEORGE L. DRENNAN, M. D., C. PAUL

WHITE, M. D., KARL L. VEHE, M. D., MISS ANN FOX, *Secretary. Educational Committee.*

### REPORT OF THE COMMITTEE ON ETHICAL RELATIONS

It is again a pleasure to be able to report that no problem of major importance has been brought to the attention of the Committee. A few rather minor questions have been propounded to the Committee, but in most cases they were mere requests for opinions, rather than regular complaints.

As a result the Committee has not been called together for a meeting. It is most encouraging to note that apparently most of the minor disagreements and differences of opinion are now settled at the local level. At the present time, we have no time for any major disagreements. Each man should endeavor at all times to be fair and honest with his brother practitioner as well as his patients so that the public will not be able to point the finger of scorn at the medical profession.

Respectfully submitted, E. S. HAMILTON, M. D., *Chairman,* CHAS. H. PHIFER, M. D., G. E. JOHNSON, M. D., *Committee on Ethical Relations.*

### REPORT OF THE FIFTY YEAR CLUB COMMITTEE

In 1938, the Council of the Illinois State Medical Society, realizing that many physicians residing in this State had been practicing fifty years or more, and wishing to do them signal honor, authorized the organization of a 50 Year Club.

The qualifications for membership in this Club were fifty years or more in the practice of medicine, and to be recommended by the officers of the County Society in whose jurisdiction they resided. A lapel button and certificate of membership, signed by the President and Secretary of the State Society, and Chairman of the Council was to be presented to each candidate initiated into this Club.

Since its organization, 707 certificates have been issued. At the present time we have 383 members; 228 downstate and 155 in Chicago.

The organization of the Club has stimulated attendance of many of the older physicians at the meetings of the State Society where they could meet, greet, enjoy and renew their friendships with their old associates who began practice during the horse and buggy days.

For a number of years the State Society has given a complimentary midday luncheon for the members of this Club. Usually, from 75 to 100 or more have attended. At these meetings members are permitted to give a short talk not to exceed five or ten minutes, relating the most interesting or most amusing experience in their practice.

Illinois was the pioneer in organizing the 50 Year Club, and our happy experience has stimulated similar organizations in several of our sister states.

Respectfully submitted, ANDY HALL, M. D., *Chairman,* CHANNING W. BARRETT, M. D., E. H. OCHSNER, M. D., H. O. MUNSON, M. D., *Fifty Year Club Committee.*

### REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health respectfully calls to your attention certain trends and patterns developing in the type of medical care provided by industry for their employees. It should be realized that Illinois is the third largest industrial state in the United States and 65 per cent of its total adult population are classified as workers in the labor force and non-agricultural employment. The demands of industrial workers for greater health and welfare benefits from employers have given rise to the following changes:

1. A definite tendency in labor-management contracts to place upon the employer the responsibility of providing for workers medical and welfare benefits beyond the scope and limitations defined in the Workmen's Compensation Act. In some instances dependents of workers are included in these provisions; the cost for this over-all medical care paid by the employer.
2. A greater number of commercial insurance companies are entering the field of group health insurance coverage wherein specified fees for surgery and other professional services are stipulated in schedules. Many employers are in the market for this type of insurance in order to fulfill the obligations of their labor contracts. These benefits, however, do not extend beyond active employment and make no provisions for medical aid to the unemployed and indigent.
3. There is evidence that the next general assembly of the State legislature will consider a compulsory sick insurance law. This type of legislation directly or indirectly involves the medical profession in its doctor-patient relationship and represents another foothold of politics in the practice of medicine.

These changes will have varying degrees of influence on all recognized fields of medical practice.

The American Medical Association through the Council on Industrial Health has been notably active in establishing a better understanding of the objectives of industrial health services and the methods of bringing these benefits to more workers on a voluntary basis at the State level. All members of our State Medical Society are urged to actively participate in formulating plans whereby the great working population of Illinois will be provided with adequate medical care during working days and periods of temporary unemployment. Management is not medically trained, but has become medically minded and can be definitely helpful toward this end. This would be a most effective answer to the challenge of socialized medicine.

The committee wishes to express appreciation to the various members of the Illinois State Medical Society who have participated with us in meetings, discussions, conferences and publication of papers on special aspects of industrial health.

Respectfully submitted, *Committee on Industrial Health,* JOSEPH H. CHIVERS, M. D., *Chairman,*

R. I. BARICKMAN, M. D., R. J. BENNETT, JR., M. D., O. B. BOYD, M. D., H. A. VONACHEN, M. D., *C. O. SAPPINGTON, M. D.

* Deceased.

DR. JOSEPH H. CHIVERS, Chicago: I have a supplementary report:

The Committee on Industrial Health appointed by the Council of the Illinois State Medical Society calls to your attention a contemplated legislative proposal for the next General Assembly which we feel will materially affect certain phases of medical service in this State. The intent of this program is to enlarge the scope, authority and enforcement activities of the State Department of Labor in such manner as to include the responsibility for conducting the medical, technical and laboratory studies of the relationship of illness to occupation among the industrial workers of Illinois. This would involve the transfer of industrial hygiene responsibility from the State Department of Public Health to the State Department of Labor.

In October 1949, Governor Stevenson requested the State Department of Labor to call a meeting of leaders of industry, labor and education to organize the plans for a Governor's Conference on Industrial Safety to be held in Chicago on May 1 and 2, 1950. Although the preliminary purpose of this conference was concerned with reducing industrial accidents in Illinois, certain technical committees on health and hygiene were appointed to prepare reports and resolutions pertaining to industrial hygiene, x-ray and radiation, air pollution, dermatitis and biologic agents as causes of occupational disability.

Unfortunately, whether intentional or otherwise, no representative of the Illinois State Medical Society, the Chicago Medical Society, any County Medical Society, or the Illinois Department of Public Health was approached or consulted regarding the appointment of representatives to serve on any committee of this all important conference. Manifestly, the problems of health, sanitation and hygiene in industry are medical problems and the responsibility of solving these problems should be delegated to a health agency qualified and trained to make objective investigations and medical reports that will serve the best interests of industry, labor and the general public. It may well be that the contemplated plan for the development of industrial hygiene and health programs in the Department of Labor is motivated by the desire of labor organizations to control the pattern of industrial medical service. This could then be enlarged to provide medical care for all illnesses, whether they be of occupational or non-occupational origin, even extending to members of the workers' family. Such a plan would be a big step toward socialized medicine.

On the basis of this information the Committee on Industrial Health believes it is of vital importance that the Illinois State Medical Society give careful consideration to the administration of industrial hygiene in Illinois. We respectfully direct your attention to the following suggestions:

1. A representation to be made to Governor Stevenson expressing the view of the Illinois State Medical Society as to the proper State agency to conduct an industrial hygiene program in Illinois.
2. That the Director of Public Health be advised of the view of the House of Delegates and furthermore that he be requested to exercise his influence for maintaining the responsibilty for industrial health activities within the Department of Public Health.
3. That the Illinois State Medical Society express its concern regarding the delegation of medical and welfare responsibilities of State government to any agency whose major function is not primarily concerned with preventive medicine and public health.

J. H. CHIVERS, M.D., *Chairman,* R. I. BARICKMAN, M.D., R. J. BENNETT, JR., M.D., O. B. BOYD, M.D., H. A. VONACHEN, M.D.

President Stevenson referred this supplementary report to the reference committee.

## REPORT OF THE MATERNAL WELFARE COMMITTEE

The Maternal Welfare Committee has had as its chief activity for the year the study of maternal mortality in Illinois, outside of the Chicago-Cook County area. The committee has met four times and reviewed the protocols of each case which was prepared for study by Dr. Newberger of the Illinois State Department of Public Health. These periods occupy from 9 a. m. to 3:00 or 4:00 p. m. with one hour out for lunch. Each case is carefully reviewed and assessed as to preventability and the committee tries to determine on whom the responsibility rests. The committee recommends in some cases that the original category under which they were listed be changed in the department of vital statistics to conform to the recommendations of the committee as to the probable cause of death. This has been done in several instances.

Letters have been written by the State Department of Public Health to the physicians who attended fatal cases asking if they wished a copy of the findings of the committee. In the case of those who wished this information a personal letter from the chairman of the committee was addressed to the doctor. Every effort was made to avoid the implication of censure or criticism of the management, but rather the educational value of the case to all parties concerned was stressed. In no case has resentment been displayed by the recipients of such letters.

The committee has discussed ways and means of making more complete reports on stillbirths and neonatal deaths in the state but as yet have no concrete proposal. The problem is a complex one and will require cooperation of many agencies for its successful solution.

Another problem that has been explored is that of developing an obstetrical committee for each hospital in the state to study the problems peculiar to that institution with a view to supplying deficiencies and correcting undesirable practices within the department, and of supplying better service conditions for the care of pregnant and parturient women.

The committee notes with satisfaction the fact that not a single patient who was attended by a doctor of medicine died outside of the Chicago area during 1949 from ectopic pregnancy. Also, it is noted that the mortality rate of .65 for the whole state is the lowest in the history of the state and one of the lowest in the nation. The committee feels that the educational efforts of the Illinois State Medical Society in furnishing information on such subjects as obstetrical hemorrhages, toxemias, and puerperal infections is an important factor in these achievements.

Respectfully submitted, F. H. FALLS, M. D., *Chairman,* A. B. OWEN, M. D., JOSEPH T. O'NEILL, M. D., W. R. YOUNG, M. D., RALPH R. LOAR, M. D., MILTON E. BITTER, M. D., CARL GREENSTEIN, M. D., CHARLES E. AHLM, M. D., W. C. SCRIVNER, M. D., JAMES C. CAREY, M. D., J. B. WALLER, M. D., *Maternal Welfare Committee.*

## REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

A system, inaugurated three years ago establishing a backlog of two articles always on hand for publication, was not successful this past year. Unfortunately, the response of individual members of the Committee has not been as satisfactory as in previous years, even with the periodic reminders that have gone to each.

Articles published and not included in last year's reports were "Our Benevolence Fund" (guest), April, 1949, and "Convalescent Hospitals," May, 1949.

Since then the following original papers have been published: "State-Aided Cancer Diagnostic Clinics" (guest), June; "Campaigns for Funds and the Doctor," September; "Medico-Legal Testimony," October; "Economic Problems in the Practice of Pathology," November; "Consultations in Obstetrics," December; "Appraisal of Quality of Medical Care," January, 1950; "Euthanasia," February, 1950; "School Physical Examinations," April, 1950.

While a paper was published in the March, 1950, issue, titled "Public Assistance Trends and Costs," actually this was an editorial assignment extraneous to the Medical Economics Committee.

Articles were not published in the July and August issues of the *Illinois Medical Journal* because of limited space. The contributions for September, October, and November were the results of the previously mentioned backlog.

Our new member of the Committee contributed the December article, and three other members submitted papers for January, February and April.

Thus it may be stated that only four of the sixteen members of the Medical Economics Committee submitted papers for the 1949-1950 period covered by this report.

With the resignation of Emmet P. Bay, Edwin F. Baker and Walter M. Whitaker, three new members were appointed to the Committee: Eugene Hamilton, John Mart and John Wolff. As of February 6, Marie Wessels submitted her resignation.

The Committee held its usual meeting during the 1949 Annual Session of the Illinois State Medical Society under the acting chairmanship of Edwin F. Hirsch because of the illness of Chauncey C. Maher.

It is regrettable that, because of Dr. Maher's illness, the recommendations emanating from this meeting have not been projected, particularly insofar as obtaining certain guest editorials.

However, one observation made at the meeting was that the Committee should adhere to the theme of the actuarial costs of medicine and contingent problems, but the Committee believed generally that this would be an overlapping and duplication of efforts now carried on by other committees.

The Committee presents this report as a frank expression that it has not completely fulfilled its objective of contributing one article per month to the *Illinois Medical Journal.*

The Committee presents the question to the House of Delegates as to whether it should continue to function or whether a new method should be sought to obtain monthly articles for the Medical Economics column in the *Journal.*

Respectfully submitted, CHAUNCEY C. MAHER, M. D., *Chairman,* HUBERT L. ALLEN, M. D., CARROLL BIRCH, M. D., T. C. BROWNING, M. D., ROLAND R. CROSS, M. D., JAMES GRAHAM, M. D., GEORGE HALPERIN, M. D., EDWIN S. HAMILTON, M. D., FORD K. HICK, M. D., EDWIN F. HIRSCH, M. D., JOHN MART, M. D., JAY McDONALD MILLIGAN, M. D., HOLLAND WILLIAMSON, M. D., JOHN R. WOLFF, M. D., EUGENE HAMILTON, M. D., *Committee on Medical Economics.*

## REPORT OF THE COMMITTEE ON MEDICAL HISTORY

The work of the Committee has proceeded satisfactorily during the past year.

Several meetings of various committee members were held in Chicago to discuss special matters as they came up.

On December 29, 1949, a general meeting was held in Chicago. The following were present: Chairman James H. Hutton, Permanent Historian D. J. Davis, Drs. Simonds, Hawkinson, Weld and Camp, Mr. James C. Leary and Miss Ella Salmonsen. Miss Salmonsen brought a considerable amount of material which had been accumulated. The work so far completed is: the history of women in medicine compiled by Dr. Helga Ruud; biographic data of all officers (Presidents, Vice Presidents, Secretaries and Treasurers) of the Illinois State Medical Society from its organization to the present date. This has never been done before.

It is hoped that a short biography of all living members of the 50 Year Club can be compiled in time for the May Meeting. Miss Salmonsen thought this would be quite appropriate for the meeting at which Andy Hall is to be honored, he being the only chairman this committee has yet had.

The work on medical journals published in Illinois from 1850 to date is coming along nicely. It is hoped to have photostats of the early journals at the exhibit with a brief history of the Journal and its editors. Any historical material that the doctors might have in their

possession, such as letters, that they would be willing to lend would be very interesting for the exhibit. Due credit would be given to that member.

Many doctors write to Dr. Camp and ask him what to do with their libraries. Miss Salmonsen suggested that they send a listing of their books and journals that they wish to give, to the John Crerar Library, 86 East Randolph Street, Chicago 1, Illinois, which will check to see if it needs any of those listed. It is no use to send books already in the library. They might be sent to other local libraries around the state. But Crerar would be very grateful for such gifts.

The biographies are being broken down so that we now have a collection on the Civil War, Legislation, Civics, Pharmacists, Farmers, etc. We still need material on Legislation which Miss Salmonsen believes can be obtained from Springfield.

Dr. Weld suggested that at each postgraduate conference held in 1950, and thereafter, it would be well to have a speaker devote perhaps ten minutes to telling what the Committee is doing, what is desired, and ask for assistance. It would be well to have the Secretary write to each county society secretary at the end of each year asking for a short report of the activities of their respective societies during the past year, the number of meetings, subjects, speakers, new members admitted, projects under way, death of physicians in the county and other similar data.

Miss Carr, Medical Librarian, and Miss Price, Reference Librarian, of Northwestern University Medical School, Mrs. Prohaska, Mrs. Friedell and Mrs. Plice of the Auxiliary have been most faithful and helpful in collecting data and they, in turn, have had the assistance of the other Auxiliary members. In fact, the Auxiliary has done a great deal.

Some counties have sent in material. Dr. J. H. Maloney of Rockford, Dr. L. S. Reavley of Sterling, Dr. E. B. Montgomery of Quincy, Dr. Andy Hall of Jefferson County and Dr. Bowles of Joliet are among those in so far.

It is thought that the work will move more rapidly in the next year.

The Committee has had the valuable assistance of Dr. Stevenson, President, Dr. Camp, Secretary, and Dr. Hawkinson, Chairman of the Council, and Mr. James C. Leary, Public Relations Council.

Respectfully submitted, *Committee on Medical History,* JAMES H. HUTTON, M. D., *Chairman,* D. J. DAVIS, M. D., *Permanent Historian,* J. P. SIMONDS, M. D., *Chairman, Chicago Medical Society History Committee,* J. J. MOORE, M. D., GEORGE W. COLEMAN, M. D., CHARLES P. BLAIR, M. D., E. H. WELD, M. D., D. D. MONROE, M. D., MISS ELLA M. SALMONSEN, *Assistant to the Historian and the Committee.*

## REPORT OF THE COMMITTEE ON MENTAL HYGIENE

The Mental Hygiene Committee discussed and acted upon the following projects:

1. The Children's Treatment Center.

The Committee approved the recommendation of the Illinois Society of Mental Hygiene for the establishment of a Children's Treatment Center by the Illinois Department of Public Welfare.

A discussion of the proposed Children's Treatment Center may be found in the pamphlet, "Planning for the Emotionally Disturbed Child," (pages 3 to 8). The booklet may be obtained through the office of the Illinois Society for Mental Hygiene.

2. Advisory Committee of the State Mental Health Authority.

The Mental Hygiene Committee is deeply interested in the work of the State Mental Health Authority. It will ask Dr. Oscar Hawkinson, who is the representative of the Illinois State Medical Society on the Mental Health Authority program, to keep it informed about the activities of his group.

3. Cooperation with the Educational Committee of the Illinois State Medical Society.

The Mental Hygiene Committee considered the advisability of sponsoring a series of lectures on mental health for expectant mothers. At the advice of Miss Ann Fox, the Secretary of the Educational Committee of the Illinois State Medical Society, it was decided to wait with this project.

The Committee, however, offered its full cooperation in the program for mental health that may be sponsored by the Educational Committee of the Illinois State Medical Society.

4. Proposed Plan for Reimbursement to the State for Care of Patients in State Mental Hospitals.

The suggestion that relatives of patients in State mental institutions should help defray the expenses for treatment was discussed. The Committee, however, will withhold its decision until a complete study of all aspects of this plan is made.

5. Admissions to Lincoln and Dixon.

The Committee deplored the prolonged waiting for admission to these institutions. It urged that the Illinois State Medical Society take action to remedy this condition.

Respectfully submitted, *Committee on Mental Hygiene,* ABRAHAM LEVINSON, M. D., *Chairman,* GERALD M. CLINE, M. D., RUDOLPH G. NOVICK, M. D., MANDEL SHERMAN, M. D., WALTER M. WHITAKER, M. D.

## REPORT OF THE COMMITTEE ON MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE

This report of the activities of the Committee on Military Affairs and Emergency Medical Service is made with promise of more definite action during the coming year. Your Committee has been stalemated during the past year by reason of no guidance having been available on the federal level until very recently. Your Committee held one meeting on March 1, 1950.

With the recent and partial development of suggested plans for civil defense by the National Security and Resources Board, the responsibility of the physician is becoming more clearly defined. The doctor's role in atomic warfare will be far reaching and by no means an enviable one. When we consider the relatively few doctors scattered among our millions of citizens, the

medical profession must take a prominent place in intelligent planning, particularly insofar as medical aid and medical resources are concerned, and be prepared to utilize effectively those resources already available and those to be made available.

The National Security and Resources Board is functioning in an advisory and counseling manner relative to plans for civil defense which it has suggested shall be organized on a State basis.

The administration of disaster relief in Illinois is under the jurisdiction of Governor Stevenson who has appointed "The Adjutant General" as the "State Director of Civil Defense." The Governor has recently issued the "Illinois Civil Defense Plan, 1949" which charges each State department and the elect-officials of each county, city, town and village, with certain responsibilities within their jurisdiction. The American National Red Cross, in conjunction with the Department of Public Health and other State departments, has given the responsibility of providing, among other services, first aid, medical care, hospitalization, food and water supplies, clothing and shelter, in cooperation with the duly constituted authorities in each governmental jurisdiction. Governmental responsibilities include, among others, public health, sanitation and quarantines.

In order to make the medical personnel, facilities and material medical resources more readily available to the citizens of Illinois, certain steps have already been taken through action of this Committee. The county medical societies have appointed a County Chairman of Civil Medical Defense Service in all but sixteen counties. These physicians, in cooperation with the duly constituted authorities in each county, participate actively in planning for county-contained disasters and will, in addition, be prepared to assist in emergency medical service in adjacent counties if the need should arise. The County Chairmen will help county organizations of medical personnel which shall be self-sufficient in personnel and supplies and planning. It is felt that no hard and fast rule should shape the plans of all county medical groups but that the "grass roots" principle should prevail inasmuch as emergency situations and needs for medical care will naturally vary with each county. Each county medical disaster organization will therefore be under the jurisdiction of the lawful authorities of that county.

Your Committee has maintained contact over the past year with the Red Cross, Illinois National Guard and the Council on National Emergency Medical Service of the American Medical Association. The latter is attempting to correlate the planning of State organizations and bring out a national pattern. It has recently issued a call for a meeting of all State and territorial chairmen and committees for emergency medical service on May 6, 1950 at the headquarters of the American Medical Association in Chicago. The members of your Committee will attend this meeting and a supplementary report will be made to the House of Delegates regarding the developments at that meeting.

Your Committee is preparing a guide to assist each County Chairman in a survey of medically trained personnel, medical housing, medical supplies and ancillary service normally available within each county and to assist in planning for a medical service in time of disaster. Related informative literature will be prepared by your Committee and forwarded to each County Chairman from time to time.

The Atomic Energy Commission, in cooperation with the National Security and Resources Board, has recently inaugurated a "teacher-trainer" course in "the medical effects of atomic bombing." Key medical personnel and other persons directly concerned with medical planning have been appointed to attend this course. These individuals, upon completion of an intensive instruction course of one week's duration, will be responsible for both proper planning and the passing on of the information gained to others in the civil defense organizations as they are developed. It is anticipated that through this plan each individual physician in the United States will eventually become instructed and familiarized with the anticipated clinical pictures and be prepared to provide essential therapy. The Chairman of your Committee has been designated by the Council to represent the Illinois State Medical Society at this Atomic Energy Commission "teacher-trainer" course.

Respectfully submitted, EARL H. BLAIR, M. D., *Chairman,* F. T. BRENNER, M. D., PLINY R. BLODGETT, M. D., PHILIP LEWIN, M. D., GILBERT EDWARDS, M. D., KENNETH H. SCHNEPP, M. D., LEO P. A. SWEENEY, M. D., *Committee on Military Affairs and Emergency Medical Service.*

DR. E. H. BLAIR, Chicago: I have the following supplementary report:

To The Members of The House of Delegates:

Since the report printed in the handbook was written, this committee has had two meetings. Its full membership attended the sixth semiannual meeting of the Council on National Emergency Medical Service, May 6 in Chicago. At that time its members learned that there is a definite need *now* for urgent action toward medical preparedness within the civil defense organization and that organized medicine has a prominent contributory part to play in the development of the entire program.

As a result of the deliberations of the committee and of information made available to it, the committee recommended to the Council that Dr. Roland R. Cross, director of the Illinois Department of Public Health, be added to its personnel. The Council approved the suggestion. This will permit better coordination as far as state and Society are concerned and strengthen the position of organized medicine.

At the same time, it brings to the work of the committee resources and data under the control of the department, for a more rapid and thorough survey and organization of medical facilities throughout Illinois and also establishes a better liaison with ancillary services and other groups involving our neighboring states.

The duties of county committee chairmen have been more clearly developed in these meetings. Their first duty will be to list and classify physicians and surgeons

only who would be available for emergency service. Later surveys will be sought covering supplementary services and various facilities. Other instructions to county chairmen already appointed will be distributed at a later date. The committee will also ask to have these instructions printed in the *Illinois Medical Journal.*

The committee also recommends:

1. Approval of a series of regional meetings to be sponsored by the Society to permit more thorough indoctrination and orientation of county chairmen by qualified authorities in natural and war disasters, including biological, atomic, psychological and chemical casualties.

2. That all postgraduate conferences held under the sponsorship of this Society in the coming year or two include talks by qualified authorities regarding medical treatment of such casualties.

A physician in any community, by that very fact, has a duty to give his best efforts to its people. Each hospital has a similar obligation. That means being prepared to give all the services which might be required of it. Each should therefore seek at once to better its position in relation to providing optimum care to casualties occurring in natural disasters to the extent that each takes an active part and each facility of every hospital is ready to serve and be augmented to meet any emergency.

EARL H. BLAIR, M.D., *Chairman,* F. T. BRENNER, JR., M.D., PLINY R. BLODGETT, M.D., PHILIP LEWIN, M.D., GILBERT EDWARDS, M.D., KENNETH H. SCHNEPP, M.D., LEO P. A. SWEENEY, M.D., ROLAND R. CROSS, M.D.

The supplementary report was referred to the reference committee.

## REPORT OF THE COMMITTEE ON NUTRITION

The Nutrition Committee had one meeting last fall with Dr. English, Dr. Coleman, and myself present. We discussed the possibility of securing an outstanding speaker on the subject of nutrition for the annual meeting. This was conveyed to the Chairman of the Council and also to the Secretary.

An effort was made to obtain a speaker on this subject at our last annual meeting but it was impossible to get this accomplished due to conditions beyond the control of the Nutrition Committee.

At the present, there does not seem to be the interest there should be in this particular important topic, but we feel that in the ensuing year added effort should be made to stimulate interest in this subject with an idea of obtaining a speaker at our next annual meeting who will be able to discuss this topic in detail because we feel that many members are now beginning to realize its increasing importance for the welfare of our country.

The chairman was appointed on the Illinois State Nutrition Committee and attended a meeting of the committee on February 23, 1950 at Springfield. This is a rather large committee and represents a number of organizations in which food and its relation to health is their outstanding interest. Various departments of the University of Illinois, the Department of Public Health, the Department of Public Welfare, Parent-Teachers, the Illinois State Dental Society and other groups were represented. In my report I told them I was embarrassed due to the fact that there was so little interest on the part of physicians and that most of them thought they could solve all nutritional problems by prescribing vitamin pills instead of giving particular directions to patients, parents and teachers on the subject of food.

We suggest that as many physicians as possible attend the Work-Shop Conference of the State Nutritional Society at the University of Illinois this summer.

Respectfully submitted, G. C. OTRICH, M.D., *Chairman,* HARLAN ENGLISH, M.D., E. P. COLEMAN, M.D., JOHN P. O'NEIL, M.D., L. J. HUGHES, M.D. *Committee on Nutrition.*

## REPORT OF COMMITTEE ON PHYSICAL THERAPY

Dr. John S. Coulter was Chairman of the Committee on Physical Therapy until his death in December, 1949.

Due to his extended illness the activities of the committee have been limited. All the literature on physical therapy has been covered and abstracts supplied to the *Journal* of the Illinois State Medical Society.

Respectfully submitted, EMIL D. W. HAUSER, M. D., *For the Chairman,* *JOHN S. COULTER, M. D., *Chairman,* H. WORLEY KENDALL, M. D., HUGH COOPER, M. D., RALPH P. PEAIRS, M. D., DISRAELI W. KOBAK, M. D., *Committee on Physical Therapy.*

**Deceased.*

## REPORT OF THE POSTGRADUATE EDUCATION COMMITTEE

It is my pleasure and privilege to submit herewith the annual report of the Postgraduate Education Committee. It is of interest to note that this is the eleventh year of existence of this Committee. Its sole function is to provide for and help conduct Postgraduate Conferences in ten of the eleven Councilor districts of the State of Illinois. Cook County covering the Third District is excluded because of its facilities and resources in graduate medical training. It should be of passing interest to list the number of Conferences held since 1939:

| | |
|---|---|
| 1939-1940 | Four |
| 1940-1941 | Nine |
| 1941-1942 | Ten |
| 1942-1943 | Four |
| 1943-1944 | Four |
| 1944-1945 | Four |
| 1945-1946 | Four |
| 1946-1947 | Ten |
| 1947-1948 | Twelve |
| 1948-1949 | Nine |

In the series of twelve authorized by the Council for the 1949-1950 season, eleven Conferences have been completed or scheduled. One surplus Con-

ference has not been assigned. This compares with the nine Conferences scheduled for the previous year. The Conferences scheduled thus far are: DISTRICT 1, March 29, 1950, Aurora, Max Sadove, Modern Anesthesiology; Max M. Montgomery, Current Therapy of Rheumatoid Arthritis; Beulah Bosselman, Role of Psychiatry in Modern Medicine; Frederick H. Falls, Breech Presentation; Philip Thorek, Acute Abdomen.

DISTRICT 2, March 23, 1940, LaSalle, John A. Mart, Coronary Disease; Irwin S. Neiman, The Newer Antibiotics; Robert E. Cummings, Differential Diagnosis of Abdominal Pain in Children; Meyer Solomon, Psychosomatic Medicine and the General Practitioner—Present Status and Practical Applications; Walter Stevenson, Cataracts, and Some Remarks as President.

DISTRICT 4, April 20, 1950, Peoria, Eugene F. Traut, Arthritis: Current Treatment; Edwin Irons, Treatment of Infectious Diseases: The Newer Antibiotics; Eugene A. Hamilton, Low Back Pain; Lindon Seed, Acute Conditions of the Abdomen: Early Diagnosis; Louis R. Limarzi, Infectious Mononucleosis; and William A. Brams, Treatment of Heart Disease.

DISTRICT 5, November 3, 1949, Springfield, Paul A. Campbell, Dizziness; Aaron Arkin, Nephritis; Percy E. Hopkins, Public Relations of the State Medical Society; David Markson, Symptomatic Treatment of Arthritis; J. Peerman Nesselrod, Ano-Rectal Disease; and Jay M. Garner, movies; Arkell M. Vaughn, Surgical Lesions of the Large Intestine.

DISTRICT 5, November 17, 1949, Pekin, Samuel M. Bluefarb, Newer Methods in Dermatologic Treatment; Lyle A. Baker, Clinical Aspects of Pericarditis; John W. Huffman, Cancer of the Cervix; Frederick H. Falls, Cesarean Section; John T. Reynolds, Diagnostic Problems and Operative Precautions in the Treatment of the Acute Surgical Abdomen.

DISTRICT 6, March 30, 1950, Jacksonville, Herbert E. Schmitz, Treatment of Gynecological Cancer; Everett P. Coleman, Trends in Medical Care; James H. Hutton, Obesity; Warren H. Cole, Pre mon Diseases of the Eye.

DISTRICT 7, December 15, 1949, Taylorville, E. Lee Dorsett, Breech Presentation and Delivery; George A. Hellmuth, Newer Aspects of Cardiovascular Disease; Harry A. Oberhelman, Surgical Problems in Infancy and Childhood; Franklin Corper, Nephritis in Childhood; Claude N. Lambert, Principles of Fracture Treatment; Edwin S. Hamilton, What the Coordinating Committee is Doing.

DISTRICT 8, October 20, 1949, Mattoon, Samuel M. Feinberg, Management of Asthma in General Practice; James H. Hutton, Hypertension; E. Lee Dorsett, Eclampsia; John T. Reynolds, Abdominal Surgery; Eric Oldberg, Cerebral Angiography.

DISTRICT 9, October 26, 1949, Mt. Vernon, Archibald L. Hoyne, Poliomyelitis; Harry M. Hedge, Dermatology as Seen by the General Practitioner; Harold M. Camp, The Fight Is Not Over; Robert S. Berghoff, Coronary Disease; Charles D. Krause, Threatened Abortion; Eugene A. Hamilton, Fundamental Principles in the Care of Fractures; Walter Stevenson, Our Society Activities, and Squint—A Medical and Economic Problem.

DISTRICT 10, April 6, 1950, Belleville, Thomas H. Hunter, Newer Antibiotics; Edmund A. Smolik, Management of Cerebral Accidents; Walter J. Siebert, Papanicolau Smears in the Early Diagnosis of Cancer; Sidney A. Portis, The Practical Approach to the Handling of Psychosomatic Problems in Patients; Philip Thorek, Acute Abdomen; Norris J. Heckel, Hematuria; Walter Stevenson, Doctors and Their Political Obligations.

DISTRICT 11, April 5, 1950, Joliet, John L. Reichert, Pediatric Emergencies—Indications for Treatment; John Martin, Indications for Treatment—Cranio-Cerebral Emergencies; N. C. Gilbert, Cardiovascular Emergencies—Indications for Treatment; Howard J. Shaughnessy, Ph.D., Laboratory Diagnosis of Virus Diseases; Charles D. Krause, Obstetrical Emergencies—Indications for Treatment; Ben Lichtenstein, Epilepsy—Diagnosis and Treatment; Mr. Ben H. Gray, The National Epilepsy League Goes to Work.

With the cooperation of the 58 speakers who participated in these sessions, it is the conviction of your Committee that (1) Postgraduate Education Conferences as at present conducted throughout the state of Illinois are popular, well attended, and that they constitute a very important and essential factor in scientific progress; (2) that they should be continued, with authorization for at least one for every Councilor District.

Respectfully submitted, ROBERT S. BERGHOFF, M. D., *Chairman,* GEORGE A. HELLMUTH, M. D., *Vice Chairman,* WARREN H. COLE, M. D., FRANK DENEEN, M. D., F. GARM NORBURY, M. D., CHARLES O. LANE, M. D., N. C. BARWASSER, M. D., R. C. OLDFIELD, M. D., *Postgraduate Education Committee.*

## REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

The Committee during the past year has concerned itself largely with two problems. The first is that of assisting local communities with the rural phase of their hospital construction and operational problems. We are taking the leading part in an effort to integrate economically, the hospital group recently opened in southeastern Illinois. Rural people appear to appreciate Medicine's efforts along these lines.

The second prominent activity of the Committee during this past year concerned itself with the selection of medical students from areas in need, where the physician population was or is low. Some of these students needed loans which was handled by the Illinois Agricultural Association and the Illinois State Medical Society's combined Loan Fund Board. Other students needed contracts to return to their home county to practice before they could enter

Medical Schools. Much personal interviewing and talking with responsible medical and farm leaders from various counties had to be done in order to do this job intelligently.

What have been the results? The State Medical Society in Illinois has probably the best relationships of any Society with the rural people of Illinois. What about the future? Eleven young men are in Medical Schools now on the Illinois Farmer and Doctor Loan Fund contract arrangement. During the next five years, fifteen students each year will be starting in medical schools under the Illinois plan. Seventy-five young well-trained medical men returning to practice in their home counties in the worst need of new medical personnel, plus the opening of new hospital facilities will go a long way toward the solution of Illinois' rural physician problem.

With continuing education of the rural people and the activities of all physicians interested in the broad problems of rural health, we of the Illinois State Medical Society will look back on a job that the Committee feels will have been a great service to the rural folk of Illinois, and to Illinois Medicine.

The Committee wishes to thank each member of the Society for his or her suggestions, and the support which we have received from so many Doctors in all kinds of capacities within the commonwealth of Illinois.

Respectfully submitted, HARLAN ENGLISH, M. D., *Chairman,* G. C. OTRICH, M. D., W. I. LEWIS, M. D., EDGAR C. COOK, M. D., J. C. REDINGTON, M. D., *Committee on Rural Medical Service.*

## REPORT OF THE SCIENTIFIC SERVICE COMMITTEE

For the twenty-first consecutive year, it is my pleasure and privilege to report to you herewith concerning the activities of the Scientific Service Committee. The year 1949-1950 has been active, satisfactory and progressive. We are listing herewith in detail the counties which have requested and received the services of this Committee:

| *Societies* | *Speakers* | *Return Post Card Notices* | *Single Post Card Notices* | *Press Releases* |
|---|---|---|---|---|
| Bureau | 7 | 812 | 139 | 185 |
| DeKalb | 4 | 336 | | 107 |
| DeWitt | | | | 82 |
| Effingham | 12 | | 901 | 257 |
| Fulton | 4 | | | |
| Henry | 7 | 746 | | 149 |
| Iroquois | 12 | 707 | | 354 |
| Kane | 3 | | | |
| Kankakee | 9 | | | 28 |
| Knox | 1 | | | |
| LaSalle | 12 | 1360 | | 404 |
| Logan | 6 | | | |
| McDonough | 8 | 961 | | 280 |
| McHenry | 6 | 549 | | 150 |
| Macon | 7 | | | |
| Macoupin-Montgomery | 3 | | | |
| Morgan | 1 | | | |
| Rock Island | 2 | | | |
| St. Clair | 3 | | | |
| Sangamon | 4 | | | |
| Six County: (Randolph, Perry, Jackson, Union, Williamson and Franklin) | 1 | 434 | | 33 |
| Stephenson | 1 | | | |
| Warren | 2 | | | |
| Whiteside-Lee | 8 | 115 | 458 | 24 |
| Will-Grundy | 6 | | | |
| Winnebago | 1 | | | |

While the summary is presented in statistical form and is self-explanatory, the twenty-six county medical societies serviced compares with a total of twenty-seven for the previous year. A total of 130 speakers for county medical societies were scheduled as against 113 for the 1948-1949 period and 73 for 1947-1948. While there was a variation in the type of service rendered, particularly in the manner of sending postcard and press releases, it is interesting to note that all societies received one or three types services.

In addition four speakers were scheduled for the Northwest Chapter of the American Academy of General Practice, and one each for the Illinois Chapter, American Academy of General Practice, Iowa and Illinois Central District Medical Association, Chicago Oral Surgery Society and the Stock Yards Branch of the Chicago Medical Society, giving a total of 138 speakers scheduled by this Committee and 20 including a period beyond this report.

Three speakers were scheduled for the St. Clair County Medical Society, but, in addition, service was extended to include 248 postcard notices, 248 programs and thirty-five press releases for a symposium on obstetrics and gynecology arranged by the society itself.

That the service extended to various societies has gone beyond the notable increase reported last year is shown by the following comparison:

| *Double Postcards* | | *Single Postcards* | | *Press Releases* | |
|---|---|---|---|---|---|
| 48-49 | 49-50 | 48-49 | 49-50 | 48-49 | 49-50 |
| 5,116 | 6,268 | 1,349 | 1,498 | 1,769 | 2,097 |

The Committee wishes to point out that whenever a physician is requested by a program chairman or secretary the designated physician is invited, leaving to him the decision to accept or decline. If the topic only is mentioned, the judgment of the Committee guides the fulfillment of the appointment. The Committee

proudly acknowledges the cooperation of the following physicians: Ladislas J. Meduna, James Graham, Lee T. Hoyt, Charles Dunham, John W. Huffman, C. Paul White, John Van Prohaska, Charles D. Krause, Henry Buxbaum, Ben Z. Rappaport, Paul A. Campbell, Philip Thorek, Charles Newberger, Danely P. Slaughter, P. H. McNulty, Frederick Slobe, Will F. Lyon, Norris J. Heckel, I. Pat Bronstein, William B. Serbin, A. R. K. Matthews, Leo P. A. Sweeney, John R. Vonachen, James H. Hutton, Alva A. Knight, Albert H. Andrews, Marc Hollander, Archibald Hoyne, George H. Rezek, James J. Callahan, Donald H. Wrork, Frederick A. Jostes, Joseph H. Kiefer, Stanley Fahlstrom, James H. Mitchell, John T. Reynolds, Samuel M. Bluefarb, Edward A. Piszczek, S. William Becker, John Huffman, Paul Hletko, Eugene A. Hamilton, Harold M. Camp, David B. Freeman, John A. Mart, L. Martin Hardy, Aaron E. Kanter, Leo Kaplan, Guy V. Pontius, C. Edward Stepan, Kurt Glaser, Paul H. Holinger, Carlo Scuderi, Arthur J. Atkinson, Israel Davidsohn, Fred W. Fitz, Eugene L. Walsh, George H. Woodruff, E. Harold Ennis, Charles N. Pease, Warren H. Cole, Charles J. Smith, George Byfield, Frank F. Maple, Samuel M. Feinberg, P. V. Dilts, Lindon Seed, Ralph A. Reis, James H. Mitchell, D. W. McKinney, Edward L. Compere, Louis R. Limarzi, Michael L. Mason, E. P. Coleman, Max Sadove, Williard O. Thompson, Felix Tornabene, Emery G. Grimm, Armand J. Mauzey, Ralph E. Dolkart, Harry J. Dooley, William F. Lauten, Harvey S. Allen, Charles N. Pease, Joseph N. Rappaport, F. Stiegmann, Harry A. Warren, Chester Coggeshall, Herbert E. Landes, William S. Hoffman, Walter Palmer, Jules Masserman, J. P. Nesselrod, Jay M. Garner, Julius Jensen, J. Keller Mack, Harry A. Gussin, John C. Scully, John B. O'Donoghue, Harry M. Hedge, Thomas D. Masters, Theodore R. Van Dellen, Harold C. Voris, Edwin Irons, Wesley A. Gustafson, Claude N. Lambert, August Daro, Martin H. Siefert, E. Harold Ennis, Richard B. Capps, Mr. George Hall, and Frank Dickinson, Ph. D.

The cooperation of the county medical societies and other scientific groups in scheduling programs well in advance is reflected in the increase of postcard and press notices and notably evidenced in the increased attendance at county medical society meetings, since this procedure permits advance publication in the Illinois Medical Journal.

A statistical study of this report, and a comparison with previous years, indicates an ever increasing spread of this service. In spite of this growth, your Committee is not completely satisfied, and is anxious that more county medical societies avail themselves of its services.

With this objective in mind, a joint meeting of the Scientific Service Committee and the Postgraduate Education Committee was held in the Bismark Hotel, Chicago, September 13, 1949. From that meeting there emerged the following resolutions:

1. That the Council of the Illinois State Medical Society authorize the Committee to add to its Speakers' List a mimeographed supplement of additional speakers, and new subjects, and that this supplement be sent to the secretary of every county medical society. The Council gave its approval, and the supplement to the Speakers' List is being processed. An editorial, titled Doctor, Is Your Name Listed? was placed for two consecutive months in the *Illinois Medical Journal,* and three consecutive issues of the *Chicago Medical Society Bulletin.*

2. It was further recommended that each Councilor urge all of the county medical societies of his district to a wider and more frequent use of the services of this Committee.

The Committee wishes to emphasize that, in addition to its regular service of supplying speakers for county medical societies, the preparation of press releases to newspapers and postcard notices to membership, it has succeeded in establishing good publicity in the *Bulletin of the Chicago Medical Society, The Illinois Medical Journal* and *The Journal of the American Medical Association.* Never before has the Committee received such widespread publicity as it has this past year.

In conclusion we, the Scientific Service Committee, wish the members of the House of Delegates to know that throughout the past year we were in constant receipt of the programs and activities of similar committees in other state medical societies, and we are convinced that by comparison the Illinois State Medical Society's Scientific Service Committee continues to hold an enviable position.

We, the Committee, acknowledge with thanks and appreciation, the tremendous help afforded us by Miss Ann Fox and her associates in the Chicago office, as well as Mrs. Frances Zimmer in the Monmouth office.

Respectfully submitted, ROBERT S. BERGHOFF, M.D., *Chairman,* LOUIS R. LIMARZI, M.D., *Vice Chairman,* ROBERT J. PATTON, M.D., WADE C. HARKER, M.D., JOHN H. GERNON, M.D., CHARLES H. HULICK, M.D., HARRY A. OBERHELMAN, M.D., CHARLES D. KRAUSE, M.D., *Scientific Service Committee.*

## REPORT OF THE COMMITTEE ON TUBERCULOSIS

A tuberculosis program anywhere can never be perfect. But efforts to improve our approach to the control of tuberculosis in Illinois mark a step toward the realization of our ultimate aim—the stamping out of the diseases in the state. In the past year we have taken several steps which will take us a long way toward that goal.

For the first time in the history of the state the legislative body has allocated a large sum of money to be used for this purpose. The 66th General Assembly appropriated funds as follows:

Senate Bill 360, $5,000,000.00—Payments for hospitalization of persons suffering from Tuberculosis

Senate Bill 362, $1,000,000.00—Repairs, Rehabilitation, Alterations and Expansion of Public T. B. Hospitals & Sanatoria.

Senate Bill 680, $759,835.00—For completion of the construction of Mt. Vernon T. B. Hospital.

Senate Bill 680, $225,000.00—For Furnishing and Equipment for Mt. Vernon T. B. Hospital.

Senate Bill 655, $4,850,000.00—Reappropriated from S. B. 662, 65th Biennium for completion of construction of State T. B. Hospital in Cook County.

Senate Bill 655, $543,183.64—Reappropriated from S. B. 662, 65th Biennium for completion of construction of State T. B. Hospital at Mt. Vernon.

This table of monies and the activities that will be stimulated shows that at last the State of Illinois has recognized its responsibility in providing the funds needed throughout the state. In addition to these state funds, the Excess Tax law will be up for a vote of the local voters to be revoted in Lee, Grundy, Will, Warren, Iroquois, Fulton, McLean, Ford, Brown, Macon, Morgan, Douglas, Fayette, Clinton, Gallatin, Montgomery and Logan Counties. In some of these counties the law as voted now will not expire until 1952, but it would be advisable to revote it early. We are including this in our report so that physicians in these counties can be informed. In Johnson County the tax will be voted for the first time in November and in Menard and Alexander Counties it was revoted for ten years. Five counties have not voted a tax—namely, Pope, Pulaski, Marshall, Jersey, and Calhoun. In the latter three counties there have been no deaths from tuberculosis in some time and the first two counties named may vote on it this year or next.

Dr. Clifton Hall, Chief, Division of Tuberculosis Control, reports that the following counties have received financial assistance through Senate Bill 360: Will, Alexander, Massac, Hardin, Ford, Effingham, Franklin, Wayne, and the MTS in Chicago. This bill was passed last spring and provides state aid to counties which spend .05 or more on the hundred for care and treatment of the tuberculous.

Dr. Hall also reports that the Rockford MTS, the Chicago MTS and the Outlook Sanatorium in Urbana have applied for similar aid. This bill offers financial assistance to existing tuberculosis hospitals and sanatoria for needed rehabilitation, alteration or expansion.

It has been reported that there seems to be some difficulty between some county medical societies and the mobile X-ray units that should be adjusted. Some societies require that all patients to be X-rayed shall first have a tuberculin test for which a charge of $1.00 per test would be made by the local physicians before the unit can come into the community. In another instance the local society set a fee of $1.00 per test for all tuberculin tests. In setting of fees for services performed for private patients is, of course, purely a local affair and does not enter into a survey program, but when the work of the Health Department's mobile unit is hampered by unreasonable restrictions it is time that the local medical men rearrange their viewpoint and take a more realistic stand on this point.

Your committee again wishes to call attention of the officers of those local county associations that have not appointed a Tuberculosis Committee to do so and report to the Secretary of the State Society the names of the committee members so that we may have the on file when needed.

Your committee again calls your attention to the tuberculosis items printed in the Illinois Medical Journal each month. The editor is to be commended for the excellent selection of the items and they are a help to the general practitioner if he will read and use them. The State Tuberculosis Association purchases the Tuberculosis Abstracts which monthly abstract an outstanding article on tuberculosis and these are distributed to physicians by the local tuberculosis association. Any physician who does not receive them monthly can get them by placing his name with the local tuberculosis association.

In Chicago energetic measures are being instituted to control tuberculosis in that city and results should soon show for this program. The voluntary local agency is cooperating with the Municipal Tuberculosis Sanatorium in giving free X-rays of the chest to residents of Chicago and Cook County. The newly organized Cook County Sanitarium District will cover the county of Cook outside of Chicago so that the metropolis will have a complete control program.

A partial report of the city-wide free chest X-ray program shows a marked step forward. We quote:

"Voluntary free chest roentgenograms of the estimated 2,300,000 Chicagoans over 15 will be provided late in 1951 to 1952 in a community-wide survey to discover undetected cases of tuberculosis. Dr. Robert J. Anderson, chief tuberculosis control officer of the U. S. Public Health Service, Washington, D. C., addressing the Tuberculosis Rehabilitation Conference of the Tuberculosis Institute of Chicago and Cook County, said that the public health service will contribute 26 mobile X-ray machines, the state six and the institute four. It is estimated that, on the basis of 16 other community surveys, it will take less than a year to cover Chicago at the rate of 400 to 500 roentgenograms a day. Half the estimated cost of $1,000,000 is to be borne by the city.

"Seventeen persons out of every 1,000 examined roentgenographically by the Tuberculosis Institute of Chicago and Cook County in 1949 were suspected of having tuberculosis, according to the institute. The total of suspect cases was 6,361, or 1.7 per cent of the 371,208 persons examined. The institute's mass examination service last year also revealed chest disorders other than tuberculosis in 3,771 persons; of these, 2,801 had heart conditions."

There has not been any startling innovations in the drug therapy of tuberculosis and at present that portion of study seems to be devoted to an evaluation of those now being used. There is still no drug that is a substitute for bed rest and other established forms of treatment. A report of the Clinical Subcommittee on Medical Research sums it up as follows:

"In many tuberculosis conditions," the report states, "there is as yet no evidence that various drugs with anti-tuberculosis properties lead to late results superior to those of such established forms of therapy as bed rest and collapse therapy, although the use of these drugs appears to be associated with

perhaps temporary favorable changes more promptly and more uniformly."

Your committee wishes to extend its thanks to all those who assisted in promoting legislation during the past year and asks for your support in the future.

The family physician is still the keystone in the arch of tuberculosis control and he is the one who will share most in the grateful thanks of the afflicted.

Respectfully submitted, FRED M. MEIXNER, M.D., *Chairman,* FRANK J. SMEJKAL, M.D., ROBERT K. CAMPBELL, M.D., JAMES H. HUTTON, M.D., O. L. BETTAG, M.D., *Committee on Tuberculosis.*

## REPORT OF THE COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

Throughout the past year, important progress has been made, in Illinois, in the field of voluntary prepayment medical and surgical care, particularly in respect to the growth and development of Blue Shield Plans.

Largest among the Blue Shield Plans in this State is Illinois Medical Service, which was formerly Chicago Medical Service. Organized under the state enabling legislation enacted through Society sponsorship in 1945, Chicago Medical Service has been extending its activities into numerous downstate counties. It was therefore considered that the name Illinois Medical Service would be more descriptive and informative, and upon approval by the Councils of the Illinois State Medical Society and the Chicago Medical Society, the change was made. Illinois Medical Service is now operating in eighteen counties, and contemplates entering several others in the very near future. Its present enrollment is in excess of one hundred eighty thousand persons, and enrollment growth is continuing at a rapid rate. Three other plans of the so-called service type are also in operation: Blue Shield Medical Surgical Plan, at Alton, Northern Illinois Medical Service Corporation, at Rockford, and the Rock Island County Medical Service. The various plans operating under the enabling legislation are working through local farm organizations and health centers to increase enrollment in rural areas.

Much less encouraging has been the progress in this field made by commercial insurance carriers under the Illinois Plan. Although the number of persons covered by the carriers operating with committee approval as a part of The Illinois Plan has risen to about two hundred twenty-five thousand, almost all of the increased coverage is underwritten by a single carrier, the Metropolitan Casualty Company. With the exception of this one concern, which is doing a splendid job, little progress in this field seems to have been made by the insurance industry generally. No additional carriers have been approved for participation in The Illinois Plan during the year, although invitations have been extended to numerous qualified companies.

The reluctance of many insurance carriers to join The Illinois Plan stems from the fact that it does not have an income limitation provision, which would oblige the attending physician to accept the insurance benefit as payment in full when caring for an insured person whose income is below a certain established level. The insurance carriers agree that a single income limitation applicable throughout the entire state would be completely unrealistic, in view of the vast differences in per capita wealth and income in the various regions of the state. But they still apparently feel that they cannot safely and effectively participate without some such provision. The Committee will doubtless give further consideration to this phase of the problem.

Another important activity of the Committee has been its continuing efforts to cooperate with organized labor in the field of prepaid medical care. The chairman and various committee members have attended literally dozens of meetings and conferences with representatives of the Chicago and Illinois Federation of Labor, in an attempt to work out mutually agreeable modifications to the Illinois enabling legislation, and to assist the labor organizations to establish, upon a sound and ethical basis, a prepaid medical, surgical and hospital plan for their members. Among the suggestions thus far made is the establishment of such a plan utilizing Blue Shield and Blue Cross coverage, augmented by a properly established and managed diagnostic clinic or center. In its work in these fields, the Committee has constantly in mind the applicable standards prescribed by the American Medical Association at its meeting in Atlantic City last June.

These meetings with labor's representatives have not yet resulted in a definite plan or program, but real progress has been made. The meetings have also served a very important public relations function, by enabling the profession to discuss common problems, upon cordial terms, with authorized spokesmen for the Illinois affiliates of the American Federation of Labor.

The Committee, and various of its members, have met upon numerous occasions with persons active in prepayment plans in other states, and with representatives of the American Medical Association. The Chairman of this Committee is a member of the correlating Committee of Council on Medical Service of the American Medical Association.

The Committee feels that the progress made to date in the field of prepayment medical care in Illinois has been encouraging, although by no means spectacular. The ratio of insured persons to total population is still small. But with a continuation of hard work, and a firm and abiding faith that the "Voluntary Way is the American Way," further important progress in this field will most certainly be made in the year ahead.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* WARREN W. FUREY, M.D., *Vice Chairman,* EDWIN S. HAMILTON, M.D., CHARLES P. BLAIR, M.D., DAVID B. FREE-

MAN, M.D., WALTER C. BORNEMEIER, M.D., W. H. PALMER, M.D., WALTER STEVENSON, M.D., *Ex Officio,* OSCAR HAWKINSON, M.D, *Ex Officio,* HAROLD M. CAMP, M.D., *Ex Officio,* JOHN W. NEAL, *Advisory,* JAMES C. LEARY, *Advisory.*

DR. PERCY HOPKINS, Chicago: I have the following supplementary report:

To the Members of The House of Delegates:

As a result of the meeting held by the Committee on May 5th, subsequent to the writing of its report for the handbook, the Committee wishes to submit the following Supplemental Report for the consideration of the House of Delegates:

Although the House of Delegates has heretofore given formal approval to The Illinois Plan, operated through the medium of established insurance carriers, no such approval has been given to the four service-type plans currently operating under the Illinois enabling legislation. These plans have in each case been devised and developed under the guidance of the local county medical society, and their rapid rate of growth continues. The four plans are Blue Shield Medical Surgical Plan, at Alton, Northern Illinois Medical Service Corporation, at Rockford, Illinois Medical Service, in Chicago, and Rock Island County Medical Service. These plans are or will soon be operating in a majority of the counties of Illinois. As of May 1st, they have achieved an aggregate enrollment of almost one-quarter million people. The Committee feels that each of these plans should receive encouragement through formal approval of their efforts by the House of Delegates, and the Committee respectfully recommends that such approval be given.

The Committee also recommends that the House of Delegates give hearty commendation to those county medical societies which have been active in the formulation of voluntary prepayment plans, and that the House also encourage all county societies to exert their best efforts in the prepayment care field.

The Committee has recently become much interested in the type of insurance recently inaugurated in California, which is designed to protect against the cost of prolonged and chronic illness. A further study is in process, and recommendation may be made to the Council at a later date in this regard.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman,* WARREN W. FUREY, M. D., *Vice-Chairman,* EDWIN S. HAMILTON, M. D., CHARLES P. BLAIR, M. D., DAVID B. FREEMAN, M. D., WALTER C. BORNEMEIER, M. D., W. L. PALMER, M. D., WALTER STEVENSON, M. D., *Ex Officio,* OSCAR HAWKINSON, M. D., *Ex Officio,* HAROLD M. CAMP, M. D., *Ex Officio,* JOHN W. NEAL, *Advisory,* JAMES C. LEARY, *Advisory.*

This supplementary report was referred to the Reference Committee by the President.

## REPORT OF THE WOMAN'S AUXILIARY

As President of the Woman's Auxiliary to the Illinois State Medical Society, I wish to submit the following report:

1. MEETINGS: Three meetings of the Board of Directors of the Woman's Auxiliary to the Illinois State Medical Society have been held this year. These include the Post Convention board meeting, the November and March board meetings. A Pre-Convention board meeting will be held on May 23, 1950 in Springfield.

The annual conference for County Presidents and Presidents-Elect was held during the November board meeting. At this conference the outline for the year's work was discussed by State officers and County Presidents.

The President has had full cooperation of all officers both state and county in carrying out the work of the Auxiliary.

2. ORGANIZATION: Organization has been one of our main objectives again this year. Since the report of one year ago we are very proud to announce the organization of six new County Auxiliaries:

McLean County organized April 23, 1949.
DeKalb County organized May 6, 1949.
La Salle County organized December 8, 1949.
Whiteside-Lee Counties organized February 9, 1950.
Edgar County organized February 22, 1950.
Macon County organized February 23, 1950.

Christian County organized April 18, 1950. Several new members-at-large have been added.

The Auxiliary now has twenty-nine (29) organized counties. Three (3) counties which do not have an Auxiliary have members affiliated with a neighboring county Auxiliary. This gives a representation in forty-nine (49) counties with a total membership of 1,646, an increase of 202 over last year.

It is most gratifying to see the growing interest among doctors' wives in Auxiliary membership.

The Auxiliary wishes to thank the Councilors of the State Society and the Presidents of the County Medical Societies for their help in our organization work.

3. BENEVOLENCE: The Auxiliary is proud to announce that the Treasurer has sent a check for $5,162.00 to the Benevolence Fund to date. This is $2,156.86 more than the entire donation last year. Five (5) counties have not sent in their contribution but will do so before the close of the year in May. Special mention should be made that one branch Auxiliary alone donated $2,200.00 to the fund this year.

4. PUBLIC RELATIONS: The Auxiliary feels this to be one of our most important phases of work. In almost all counties Public Relations programs were held and were well received. In this way the Auxiliary has continued to develop and maintain contacts with other organizations. A great many resolutions have been obtained from women's organizations opposing the Compulsory Health Program.

5. LEGISLATION: This year has found this department a busy one. Much literature has been distributed to lay groups and qualified speakers from the Auxiliary have spoken against the proposed Compulsory

Health Program, all counties have cooperated. The legislation chairman has kept in close contact with the national chairman and with the county legislation chairmen. Each county chairman is receiving the Washington Bulletin sent out by the American Medical Association so they have authentic and up-to-date information to present. It is the earnest hope of Auxiliary members, singly and collectively, that we may continue to help in this important fight to combat Political Medicine.

6. TODAY'S HEALTH (formerly Hygeia) This authentic health magazine has been placed in schools, libraries, waiting rooms, hospitals and many other public places. By doing this the Auxiliary hopes to stimulate better health education and in turn better living for more people.

7. SCHOOL OF INSTRUCTION: Three Schools of Instruction were held this year, in Danville, Springfield and Chicago. These schools were conducted by our Directors for the purpose of instructing the Auxiliary members in the ideals and purposes of the organization and the duties of its officers.

Illinois is one of the pioneers in holding Schools of Instruction. We are very proud that the National Auxiliary has asked us to help in formulating plans to put the School of Instruction on a National basis.

8. MEDICAL HISTORY: The Auxiliary has continued with the work of filling out history blanks which pertain to deceased doctors. Many members throughout the state have spent long hours doing this research work. The Cook County Auxiliary with the aid of Miss Salmonsen is checking and filing the blanks as they come in from all over the state.

The Auxiliary is very glad to help in this worthy project.

9. NEWS PUBLICATION: The Auxiliary approved at its March 1950 board meeting the editing on a very small and simple scale of a news publication. This would be a means of banding the counties together for a better understanding of Auxiliary work and for good fellowship. The Auxiliary would appreciate an opinion from the Society on the advisability of such a venture.

10. PRESIDENT: As President I have visited the following county auxiliaries: Bureau, Cook, Logar Peoria, Sangamon and Vermilion. Also the following Cook County branch Auxiliaries: Aux Plaines, Calumet, Englewood, Jackson Park, North Side, North Shore and South Chicago. Invitations have been accepted to visit Adams, DeKalb, Madison, Kane, Marion-Clinton, Rock Island, and St. Clair Counties before the close of the year.

The second Speakers' Training Conference of the Illinois State Medical Society held in Chicago last September was attended by the state President as well as all county Presidents. As in former years the President attended the Illinois State-wide Public Health Committee meeting held in Waukegan in September. The annual meeting of the Woman's Auxiliary to the Indiana State Medical Society held in Indianapolis in September was also attended. Much inspiration is gained from visiting the neighboring state auxiliaries.

The annual convention of the Women's Auxiliary to the American Medical Association held in Atlantic City in June 1949 was attended, as well as the sixth annual National Conference for State Presidents and Presidents-Elect held in Chicago in November, 1949. This conference is held for the purpose of exchanging ideas and talking over our problems. These discussions tend to make a more understanding and closely knit organization.

A close and friendly contact has been kept at all times between the state and county officers. Instructions pertaining to the duties of their offices were given to all county chairmen at the beginning of the year. Each officer, state and county, has done her job willingly and graciously. The spirit of cooperation has been evident throughout the year.

As President, on behalf of the Auxiliary, I wish to thank Dr. Walter Stevenson, President; Dr. Darwin B. Pond, chairman, Advisory Committee of the Illinois State Medical Society; and committee members, Dr. Harold M. Camp, Dr. H. Kenneth Scatliff, Dr. E. G. Beatty and Dr. Walter Bornemeier for their splendid cooperation and encouragement throughout the year. It has been a privilege and a pleasure to work for and with them.

The members of our organization keep in mind that we are an Auxiliary and as such we are ready and willing to do all we can to assist the Illinois State Medical Society in whatever endeavor they may assign to us.

Respectfully submitted, GERTRUDE W. EGAN, *President, Woman's Auxiliary.*

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THE PRESIDENT: There is no unfinished business so we will take up the introduction of resolutions and the reference of the same to the proper Committee. Do you wish to have the resolutions read in full or by title?

DR. A. J. SULLIVAN, Chicago: I move that the resolutions be read by title. (Motion seconded by Dr. Robert Hayes and carried).

DR. ROBERT H. HAYES, Chicago: I wish to present the following resolution from the Illinois Chapter of the American College of Chest Physicians:

1. *Establishment of a Section of Diseases of the Chest.*

*Whereas,* The American Medical Association has by authority of its House of Delegates established a Section on Diseases of the Chest in its Scientific Assembly, and there are in Illinois 117 active members of the American College of Chest Physicians and

*Whereas,* The New York State Medical Society and the Medical Society of the State of New Jersey have established Sections on Diseases of the Chest in their Scientific Assemblies, and

*Whereas,* These sections in the American Medical Association and the State Medical Societies have been well attended, and

*Whereas,* The specialty of diseases of the chest covers a broad field of important chronic and pernicious diseases affecting the thorax, and

*Whereas,* There is not a sufficient amount of time allocated in the General Assembly for the presentation

and discussion of the many problems concerned with diseases of the chest,

*Therefore, Be It Resolved,* That the Illinois State Medical Society through proper action by its House of Delegates assembled in Springfield, Illinois, the 23rd of May, 1950, establish a Section on Diseases of the Chest in its Scientific Assembly.

DR. W. W. FULLERTON, Steeleville: I wish to present the following resolution:

*2. Prosecution of Non-Licensed Practitioners.*

The Randolph County Medical Society meeting in regular session, March 23, 1950 advised the Randolph County Medical Society Committee on Resolutions to prepare the following resolutions to be presented by the delegate from Randolph County to the House of Delegates of the Illinois State Medical Society during the regular 1950 session.

*Whereas,* the number of unlicensed pseudo-healers in the State of Illinois has increased greatly in the past year, and

*Whereas,* the people of the state are being subjected to high pressure salesmanship methods of these illegal practitioners who exploit the sick offering fabulous cures or making non-existing diagnoses, and

*Whereas,* the sick are thereby harmed by the withholding of scientific and approved diagnostic and therapeutic measures,

*Therefore,* be it resolved that the House of Delegates recommend to the legislature that they enact more stringent laws providing for more severe penalties for violation of the licensure acts and stiff penalties for those practicing without license.

*Be It Further Resolved* that the Department of Registration and Education be encouraged and complimented in their efforts to prosecute violators and encourage them to continue to improve their policing methods.

*Be It Further Resolved,* that all of the States Attorneys be encouraged with approval of the House of Delegates of the Illinois State Medical Society, to adequately prosecute violators and non-licensed practitioners to prosecute vigorously with the assurance that the House of Delegates of Illinois State Medical Society will lend all possible encouragement.

DR. F. H. BIHSS, East St. Louis: I wish to present the following resolution:

*3. Reaffirmation of the Principles of the So-called Hess Report.*

*Whereas,* Chapter III, Article VI, Section 6, of the recently adopted revised Principles of Ethics of the American Medical Association reads:

"Purveyal of Medical Service"

Section 6. — A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

*Whereas:* The committee known as the "Hess" Committee reported to the American Medical Association House of Delegates in Atlantic City in June, 1949, in detail, regarding the Practice of Medicine by Hospitals.

*Whereas:* The "Hess" report in one paragraph stated in explanation as follows: "Therefore, hospitals and medical schools cannot charge patients fees for medical services rendered by physicians even though the physicians are full time employees of an individual institution."

*Whereas:* The "Hess" report was adopted by the American Medical Association House of Delegates and the Trustees of the American Medical Association were instructed to enforce the principles and obligations involved.

*Whereas:* The House of Delegates of the American Medical Association in Washington in December, 1949, reaffirmed its belief in and confirmed the principles stated in the Hess report and directed that action by the Trustees be deferred only until all legal requirements were met in order to insure that all action taken shall comply with the law.

*Whereas:* The Trustees of the American Medical Association are to report to the House of Delegates in June, 1950, regarding this matter and the "Hess" Committee is to report its further study.

*Therefore, be it Resolved:* The House of Delegates of the Illinois State Medical Society confirms the action of the American Medical Association House of Delegates regarding the reaffirmation of the Principles of the so-called "Hess" report.

*Be it Further Resolved:* The House of Delegates of the Illinois State Medical Society requests the American Medical Association House of Delegates to expedite action and implement methods that *will* enforce the Section 6, Article VI, Chapter III of the Principles of Medical Ethics without delay.

*Be it Further Resolved:* Our delegates to the American Medical Association are hereby instructed regarding these desires and requested to work for their fulfillment.

DR. R. F. SONDAG, Murphysboro: I have three resolutions to present:

*4. Disapproval of the Method of Collecting A.M.A. Dues.*

*Whereas,* the American Medical Association at its 1949 Interim session voted to levy $25.00 yearly dues for membership, and

*Whereas,* the American Medical Association requested that each State Medical Society assume responsibility for collecting the said $25.00 from each member of the American Medical Association in each respective state, and remitting same to the Central Office of the American Medical Association, and

*Whereas,* the American Medical Association allegedly made the above request because of lack of administrative personnel and insufficient planning to handle the collection, and,

*Whereas,* the Council of the Illinois State Medical Society instructed its Secretary to have printed and circulated, receipt blanks listing the County dues, State dues, and American Medical Association dues *All* on one blank and thereby making membership in the

American Medical Association mandatory for continued membership in the County and State Medical Societies, and

*Whereas,* Professional Liability Insurance is granted and appointments of different types are made with the understanding that membership is held in the County Medical Society and State Medical Society *only.*

*Be It Therefore Resolved,* that the Jackson County Medical Society, although 100 per cent AMA members, express its complete disapproval of the above method of collecting dues and respectfully request that the Illinois State Medical Society set up proper machinery for collecting its own dues without making membership in the American Medical Association mandatory or otherwise denying the component County Society any of its traditional AUTONOMY as set out in the Constitution and By Laws of the Illinois State Medical Society, and Be It Further Resolved that a request be made that this resolution be read on the floor of the House of Delegates of the ILLINOIS STATE MEDICAL SOCIETY at its 1950 Annual Meeting.

M. J. Hughes, M.D. — President Jackson County Medical Society

E. K. Ellis, M.D., Sec. Jackson County Medical Society

5. *Regulations of the Illinois Public Aid Commission Concerning Penicillin*

*Whereas,* the Illinois Public Aid Commission has seen fit to adopt regulations whereby penicillin must be furnished at cost by the physician to recipients of Old Age Assistance, Aid to Dependent Children and Blind Pensioners; and said penicillin is to be injected by the physician at no charge, and that due to the fact the prices of drugs and expenses associated with their distribution vary from time to time and place to place, and

*Whereas,* the Illinois Public Aid Commission has published regulations regarding hospitalization of recipients, and said regulations are impractical in that they penalize hospitals for lack of physician's reports being completed prior to the patient's admission; and said physician's reports are deemed unnecessary, and further that said regulations requiring prior approval for elective surgery places the Medical Advisory Committee in the embarrassing position of sitting in judgment of the diagnosis and proposed treatment of a fellow physician.

*Be it Therefore Resolved,* by the Jackson, Jefferson, Alexander, Franklin, Saline, St. Clair, Hamilton, White, Union and Randolph County Medical Societies that the Illinois State Medical Advisory Committee requests reconsideration of the above regulations by the Illinois Public Aid Commission and attempt to arrive at a more equitable fee for injection of penicillin and that a fair and equitable average table of allowances be set up and that justifiable variations from this table be allowable by the County Medical Advisory Committee, and to attempt to formulate a more workable plan regarding hospitalization of recipients of old age assistance, aid to dependent children, and blind pensioners.

*Be it Further Resolved,* that the Illinois State Medical Advisory Committee re-emphasize its desire for continued cooperation with the Illinois Public Aid Commission by investigating and making recommendations on any authenticated case of ill advised or long standing hospitalization or any other authenticated professional misconduct on the part of any member of the Illinois State Medical Society. Be it further resolved that a request be made that this resolution be read on the floor of the House of Delegates of the Illinois State Medical Society at its annual meeting, 1950.

M. J. Hughes, M.D., President, Jackson County Medical Society

E. K. Ellis, M.D., Secretary, Jackson County Medical Society

6. *Appointment of a Fee Committee to Consult with any Non-Tax Supported Group Desiring Medical Service For Its Members.*

*Whereas,* the present trend of Labor contracts includes Medical Service for Union members and their families, and

*Whereas,* the Illinois State Medical Society is the proper representative of the Medical Profession in this state, and

*Whereas,* it would seem desirable to have a standard and reliable source of information and consultation for organizations seeking medical service for its members.

*Be it Therefore Resolved,* by the Jackson County Medical Society that the Illinois State Medical Society be requested to appoint a FEE committee to consult with any NON-TAX SUPPORTED group desiring medical service for its members.

*Be It Further Resolved,* that the Councillor of each District of the Illinois State Medical Society appoint a Chairman of the Councillor District Fee Committee who will in turn appoint members of the Councillor District Fee Committee. The duties of the said Councillor District Fee Committee shall be that of making necessary and indicated adjustments in fee schedules and investigating and assisting in arbitrating any differences that might arise.

*Be It Further Resolved,* that adequate publicity be given so that all Organizations will know that the above committee exists and is ready to assist in formulating a medical program for their group if such is desired.

*Be It Further Resolved,* that each member in good standing in the Illinois State Medical Society be furnished with a certificate of Membership suitable for framing and display in his office so that members of all organizations can readily identify said member as being part of *organized medicine.*

*Be It Further Resolved,* that a request be made that this resolution be read on the floor of the House of Delegates of the Illinois State Medical Society at its 1950 Annual Meeting.

M. J. Hughes, M.D., President, Edward K. Ellis, M.D., Sec., Jackson County Medical Society.

DR. J. C. REDINGTON, Galesburg: I wish to present the following resolution from Knox County:

7. *Opposition to Enactment of Federal Legislation Embodied in H.R.* 5865, *S.* 1411 *and H.R.* 5940.

*Whereas,* The State of Illinois, in the sum total of Federal taxes paid, is second only to the State of New York, and

*Whereas,* The theory of Federal grants-in-aid is,

therefore, not acceptable — rather should it be recognized that it is through State grants-in-aid that the Federal Government exists, and

*Whereas,* The Federal grant-in-aid is inevitably accompanied by its natural corollary, Federal control, acknowledged by a decision of the Supreme Court; and such control is a basic provision of the pending so called "fringe" Bills, and

*Whereas,* The designation "fringe" is in itself a misnomer, as these Bills are integral parts of the National Health Plan, as expressed in the Wagner, Murray, Dingell Bills, or closely allied thereto, and

*Whereas,* The "fringe" Bills were all passed unanimously by the Senate and their House versions are now under consideration by a House committee and, thus, likely to reach the floor of the House at any moment, and

*Whereas,* These Bills, if enacted into Law, in addition to the Basic Federal control prescribed, would

(1) *H.R.* 5865 — Local Public Health Units
destroy the present legal arrangement whereby the State of Illinois has complete authority over the administration of all Federal funds received for public health purposes, vesting this authority in the Surgeon General,
include in the program of "basic public health services", by definition, *detection and diagnosis of chronic diseases and such other services concerned with the maintenance, protection, or improvement of the public health as the Surgeon General, with the approval of the annual conference of State health authorities, may prescribe,*
and elevate the Surgeon General to the position of supreme dictator through a set of Regulations to be promulgated, prescribed, and administered by him with agreement of State health authorities only "insofar as (is) practicable", and which would have the force of Law, although not actually written into the Law,

(2) *S.* 1411 — School Health Services
among other provisions for free periodic medical and dental examinations for all school children and free medical and dental services for the children of medically indigent parents, would *permit,* at the option of the State, free "prevention and treatment of physical and mental defects and conditions for all school children" — estimated at 30,000,000 — regardless of the economic status of the parents,

(3) *H.R.* 5940 — Medical Education
would seriously threaten the academic freedom of the medical and other institutions to be endowed, as well as the education of medical and other health personnel of the States which would receive grants for scholarships and, based as it is upon a fallacious calculation of a shortage of medical and other health personnel and upon the anticipated requirements of a system of compulsory sickness insurance, could only result in the hastening of the nationalization of medicine, and

now therefore be it

*Resolved,* that the Knox County Medical Society express its unalterable opposition to the enactment of the Federal legislation embodied in the three Bills enumerated, which may be imminent, and be it

*Further Resolved,* that the Illinois State Medical Society be requested to use its best efforts and influence to defeat all of these measures and that it make this same recommendation to the American Medical Association, and be it

*Further Resolved,* that the Illinois State Medical Society be urged to influence the State Department of Public Health to desist from the practice of applying sanctions in the form of a denial of public health services or in any other manner against the counties that refuse to vote on local health units in order to participate in the Federal-State plan as embodied in the first mentioned Bill, H.R. 5865, and other legislation covering the same subject, and be it

*Further Resolved,* that the Delegate of this Society be instructed to present this Resolution to the House of Delegates at the Annual Meeting of the Illinois State Medical Society in Springfield, Illinois, on May 23, 1950.

DR. EDWARD H. WELD, Rockford: I wish to present the following resolution:

8. *Medical Benevolence Fund*

*Whereas,* The Medical Benevolence Fund of the Illinois State Medical Society, established in 1940, is recognized as a worthy and laudable responsibility and as a cohesive force within the Society which should be continued, and

*Whereas,* during the ten (10) years of its existence the Fund has cared for approximately sixty (60) beneficiaries at the cost of nearly forty thousand dollars, and

*Whereas,* the present economic confusion in our Country today, and good common sense, proves that a "Pay-as-you-go" plan provides a sounder basis,

*Therefore Be It Resolved,* that the Winnebago County Medical Society disapproves of the Accumulation of a Benevolent Fund of some four hundred to five hundred thousand dollars which would take from twelve to fifteen years to become self-sustaining,

*Be It Further Resolved,* that the House of Delegates of the Illinois State Medical Society be emphatically requested to amend its By-Laws and to substitute a "Pay-as-you-go" plan in place of a self-sustaining Endowment Fund, and

*Be It Further Resolved,* that the Delegates of this Society be instructed to present this resolution to the House of Delegates at the Annual Meeting of the Illinois State Medical Society in Springfield, Illinois, on May 23, 1950.

DR. CHARLES ALLISON, Kankakee: I wish to present the following resolution from the Kankakee County Medical Society:

9. *Physicians Employed on a Full Time Basis in State Institutions Should Refrain From The Private Practice of Medicine*

*Whereas,* The Kankakee County Medical Society in regular session instructed its delegate to present to this House of Delegates the following resolution:

1. That physicians employed on a full time basis in State institutions refrain from the private practice of

Medicine, and that,

2. the Secretary of the I.S.M.S. be instructed to so inform the Department of Public Welfare of this action on the part of our House.

Charles Allison, M.D., Kankakee County Medical Society

DR. R. M. WATROUS, North Chicago: I wish to present the following resolution from the Lake County Medical Society:

10. *Revision In Fees Paid by Illinois Public Aid Commission*

*Whereas,* The fees paid by the Illinois Public Aid Commission to doctors have not been revised in many years,

*Whereas,* All costs have risen during this period, including doctors' fees,

*Whereas,* In Lake County, the Illinois Public Aid Commission's fee schedule now amounts to but one half the fees set and published by the Lake County Medical Society in their minimum fee schedule, adopted in 1947,

*Whereas,* This same condition prevails in many other counties, and

*Whereas,* There is no local remedy for this, since the fees payable by local Public Aid officials are set at the state level,

*Therefore Be It Resolved,* that the Medical Advisory Committee to the Illinois Public Aid Commission shall make such representations as are necessary to secure an upward revision in fees for all counties in the state.

R. M. Watrous, M.D.

DR. DALE E. SCHOLZ, Lawrenceville: I wish to present two resolutions, one from the Lawrence County Medical Society and the other from the Section on Public Health and Hygiene.

11. *Payment of Medical Bills by Old Age Pensioners and Aid to Dependent Children*

*Whereas,* there has been considerable dissatisfaction among the members of the Medical Society of the method by which the Old Age Pensioners and the Aid to Dependent Children are taking care of their medical bills, we, the members of the Lawrence County Medical Society feel that some improvement in the method of paying these bills should be made.

*Whereas,* it has been the experience of our members over the past several years that a certain percentage of their Old Age Pensioners and Aid to Dependent Children failed to pay the doctor his fees. Under the present set up the doctor is powerless to collect.

*Whereas,* many of these patients call as many as three or four doctors in one month's time; or change doctors after having failed to pay the doctor the amount sent to them for him.

*Whereas,* this abuse has gone to such an extent that some of the doctors do not take the interest in Old Age Pensioners and Aid to Dependent Children cases they would if they knew their fees would be paid. Many feel the profession is contributing to delinquency or fraud in permitting these patients to use funds apportioned to the doctor for other uses.

*Whereas,* we feel that the condition could be corrected by sending payment direct to the doctor or making checks payable to the patient and doctor, requiring endorsement of all concerned before cashing.

*Whereas,* it is understood that our neighboring State of Indiana sends the checks direct to the doctor.

*Whereas,* in consideration of the above, we, the members of the Lawrence County Medical Society, voted in regular meeting, May 3, 1950, to send to the meeting of the State Society, the following resolution for your consideration:

*Therefore, be it Resolved that*: The State Society see that plan for paying for medical fees for Old Age Pensioners and Aid to Dependent Children will be changed so that the doctor rendering the services will be paid either direct or the check be drawn jointly with the doctor so that it requires his signature before being cashed.

Lawrence County Medical Society
By Resolution Committee

12. *Change in Name for Section on Public Health and Hygiene*

*Whereas,* the Illinois State Medical Society has for many years maintained a section entitled the "Section on Public Health and Hygiene", and

*Whereas,* the field of medical science encompassed by the business of this Section has been the subject of a Specialty Board entitled "Preventive Medicine and Public Health", and

*Whereas,* the title "Preventive Medicine and Public Health" is a more appropriate term for this Section, therefore be it

*Resolved,* that the House of Delegates assembled in Annual Meeting at Springfield, May 23-24-25, 1950, change the name of the Section on Public Health and Hygiene so that henceforth it may be called the "Section on Preventive Medicine and Public Health".

DR. C. PAUL WHITE, Kewanee: I do not wish to be presumptuous on my time but we do feel that this resolution is of vital importance to the Society as a whole and that it requires the guidance of this group. Those of you who have read the report of the Educational Committee will recognize there is a great deal of work going on. As a member of that Committee I will say that the work has all been done so pleasantly and there has been a lot of fine public relations established. However, physicians are often asked to express an opinion on the radio and that opinion may not be approved by the Society. Therefore, I am offering this resolution to take care of this situation:

13. *Clearance From the Educational Committee on Talks Concerning Health and Medical Care to be given on Radio or Television Programs.*

*Whereas,* physicians in Illinois frequently are asked to discuss health and medical care over radio and on television, and

*Whereas,* an increasing number each year are asked to present subjects such as medical care under a compulsory system, and

*Whereas,* a physician so appearing speaks not only as an individual but as a representative of the 10,000 members of the profession who compose the Illinois State Medical Society,

*Therefore Be It Resolved,* that the House of Delegates of the Illinois State Medical Society in session on

this 23rd day of May, 1950, do hereby urge that all physicians discussing matters of health and medical care especially over radio or on television programs, first, obtain for themselves and the subject matter to be presented, ethical clearance from the Educational Committee, or the Committee on Medical Service and Public Relations of the Illinois State Medical Society before making their broadcast.

THE PRESIDENT: We have a number of resolutions which were sent to the Secretary which he will read by title:

14. *Establishment of Section on Allergy*

*Whereas,* it has been established that 10 per cent of the population suffers from symptoms associated with allergy;

*Whereas,* 1 patient in 4 coming into the office of general practitioners complains of allergic symptoms;

*Whereas,* allergy is intimately associated with the practice of internal medicine, pediatrics, otolaryngology, dermatology, ophthalmology, and neurology;

*Whereas,* the general practitioner has had difficulty in keeping up with the advances of allergy;

*Whereas,* there is now a Session Program on Allergy, in conjunction with the Annual Meeting of the American Medical Association;

*Whereas,* there are now two national societies and one international society, as well as numerous local societies, limited to Allergy;

*Whereas,* the Chicago Society of Allergy, composed of 75 active members limited or using allergy in the majority of their practice, approved the following resolution:

*Be It Hereby Resolved,* that the Illinois State Medical Society give favorable consideration to the establishment of a Section On Allergy.

If this be not advisable at this time, the undersigned would recommend to those responsible for the Annual program of I.S.M.S. that a joint meeting of one of the sections and a specially created Subsection On Allergy be approved: or that special consideration be given to the presentation of papers at the program of the General Meeting.

Morris A. Kaplan, M.D., Pres.
Chicago Society of Allergy

15. *Change In Title for Section On Public Health and Hygiene*

*Whereas,* the Illinois State Medical Society has for many years maintained a section entitled the "Section on Public Health and Hygiene", and

*Whereas,* the field of medical science encompassed by the business of this Section has been the subject of a Specialty Board entitled "Preventive Medicine and Public Health", and

*Whereas,* the title "Preventive Medicine and Public Health" is a more appropriate term for this Section, therefore be it

*Resolved,* that the House of Delegates assembled in Annual Meeting at Springfield May 23-24-25, 1950, change the name of the Section on Public Health and Hygiene so that henceforth it may be called the "Section on Preventive Medicine and Public Health".

16. *The Central Illinois Pediatric Society Opposes Any Form of Compulsory Health Insurance or Any System of Political Medicine*

*Whereas,* the United States has the highest standards of health, of medical care, and of scientific medical facilities of any country in the world, as a result of our system of free enterprise; and

*Whereas,* Compulsory Health Insurance, wherever tried, has caused a decline in National health and deterioration of medical standards and facilities; and

*Whereas,* wherever the Government has assumed control of medical services, the result has been tremendous multiplication of costs over original estimates, extreme tax burdens and National deficits, and gradual extension of socialization into other activities of National life, Now, Therefore,

*Be It Resolved,* that the Central Illinois Pediatric Society does hereby go on record against any form of Compulsory Health Insurance or any system of political medicine designed for National bureaucratic control;

That a copy of this resolution be forwarded to each Senator from the State of Illinois, and the Representative from our District, and that said Senators and Representative be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

Gerald Cline, M.D., President
Carl E. Sibilsky, M.D., Secretary

THE SECRETARY: I have several resolutions that came to the President and President-Elect and to your Secretary from men interested in Diabetic work in which they make a national appeal to medical societies and medical people to recommend to their diabetic patients that they make their own sugar tests and if they find anything wrong to see their doctor. They hope this House of Delegates will go on record as approving this resolution. It has come from several men who are unusually interested in diabetes.

17. *Diabetes Detection Drive of the American Diabetes Ass'n.*

*Whereas,* the early detection of diabetes mellitus is necessary for the welfare of those having the disease; and

*Whereas,* studies indicate that it is necessary to screen a large number of persons prior to confirmatory diagnostic examinations by physicians in order to find the estimated one million unknown diabetics; and

*Whereas,* The American Medical Association has already recognized the need for an organized program by approving the Diabetes Detection Drive of the American Diabetes Association; and

*Whereas,* the principle of individuals testing their own urine for glycosuria, including the recommendation that individuals with positive tests consult their own physicians, has been approved by the American Diabetes Association; and

*Whereas,* for many years the medical profession has urged diabetics to test themselves for glycosuria, and simple methods are now available to all individuals for self-use in detection of glycosuria; therefore be it

*Resolved,* that as a means of facilitating the detection of diabetes, the House of Delegates of the American Medical Association approve the principle of individuals

periodically testing themselves for glycosuria and reporting abnormal results to their own physicians.

THE SECRETARY: The following resolution was received from Dr. Herbert Ratner, Secretary- Treasurer of the Illinois Association of Medical Health Officers. It was approved at the spring meeting of the Association held April 21, 1950.

18. *Change in Name of Section on Public Health and Hygiene*

*Whereas,* The Illinois State Medical Society has for many years maintained a section entitled the "Section on Public Health and Hygiene", and

*Whereas,* the field of medical science encompassed by the business of this Section has been the subject of a Specialty Board entitled "Preventive Medicine and Public Health", and

*Whereas,* the title "Preventive Medicine and Public Health" is a more appropriate term for this Section, therefore be it

*Resolved,* that the Illinois Health Officers Association assembled in Springfield April 21, 1950 urge the Illinois State Medical Society in its Annual Meeting at Springfield, May 23-24-25, 1950 to institute measures to change the name of the Section on Public Health and Hygiene so that henceforth it may be called the "Section on Preventive Medicine and Public Health."

THE SECRETARY: The following resolution was approved at the eleventh annual convention of the National Association of Medical-Dental Bureaus, Inc., September 21, 1949, and is sent to us with the request that we adopt a similar resolution.

19. *Opposition to Compulsory Health Insurance and Other Forms of Political Medicine by the National Association of Medical-Dental Bureaus, Inc.*

*Whereas,* the medical and dental professions of this country have established the world's highest standard of health care under a system of free enterprise, thereby helping the United States to become the healthiest major nation in the world; and,

*Whereas,* the benefits of this high standard are now available to the majority of the people of this country and are rapidly being extended to all others through voluntary health insurance plans; and,

*Whereas,* the government control of medical and dental services in other countries has resulted in a gradual breakdown of free enterprise and a progressive deterioration of professional standards, to the detriment of the health of the people; and,

*Whereas,* it is the opinion of the members of this Association that it is not in the interests of the people of this country to place health facilities under any form of federal control; now, therefore,

*Be It Resolved,* That the National Association of Medical-Dental Bureaus, Inc., meeting in its eleventh annual convention in Denver, Colorado, September 21, 1949, does hereby go on record against any form of compulsory health insurance or any system of political medicine inevitably resulting in bureaucratic control; and

That a copy of this Resolution be forwarded to the President of the United States, to each Senator and Representative now in the Congress of the United States, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

G. A. Moseley, President,
John T. Mock, Secretary

THE PRESIDENT: All of these Reference Committees are open to anyone who wishes to attend. The place and hour of meeting will be posted on the bulletin board.

I wish to introduce Dr. Theodore Van Dellen, associate Editor of the Journal. I would like to have him say a few words.

DR. VAN DELLEN: I have been Assistant Editor to Dr. Camp for over a year and I have enjoyed the work.

THE PRESIDENT: I have a very nice surprise for you, I do not see anything on the agenda about it but it requires that I introduce Dr. Andy Hall who is the most famous doctor in the United States.

DR. ANDY HALL, Mt. Vernon: Fellow physicians and others: I want to express my sincere thanks to my medical friends throughout the state of Illinois and the many friends outside of Illinois for the high honor that they conferred upon me in December. The Illinois State Medical Society conferred the same honor some time before. It means more to me than a million dollars. I have lived 85 years in Illinois and have been in general practice in the state of Illinois for more than 60 years. The honor that was conferred upon me as a general practitioner is an honor that goes out to the general practitioners throughout the land, many of whose names will never be inscribed on any roll of honor, yet they are patiently, quietly, effectively and efficiently discharging their duty of preventing disease, relieving pain and prolonging lives and adding to the sum of human happiness. I thank you.

THE SECRETARY: I also want to say a word relative to a man who for many years attended all the meetings of the Illinois State Medical Society. He has been quite ill and is now disabled. He is a resident of Springfield and he sincerely regrets his inability to be present and greet his many friends. I think it would be suitable if a telegram were sent to Dr. Don Deal.

DR. MATHER PFEIFFENBERGER, Alton: I so move. (Motion seconded by Dr. E. E. Davis, Avon and carried).

THE SECRETARY: For several years it has been the custom of this House to also send an expression of greetings and best wishes to a man who was a member of the Council of this Society and attended every meeting. He has been disabled for the last 6 or 7 years. I refer to Dr. Charles E. Wilkinson of Danville.

DR. W. E. KITTLER, Rochelle: I move that we send Dr. Wilkinson a telegram. (Motion seconded by Dr. L. J. Hughes, Elgin and carried).

THE PRESIDENT: There being no further business I shall entertain a motion to adjourn.

DR. H. K. SCATLIFF, Chicago: I move we adjourn to meet again on Thursday at 9 A.M. (Motion seconded by Dr. W. E. Kittler, Rochelle and carried).

Adjournment.

# NEWS OF THE STATE



## CHAMPAIGN

**Society News.**—Dr. Henry T. Ricketts, University of Chicago School of Medicine, addressed the Champaign County Medical Society recently on "The Newer Concepts in the Etiology and Treatment of Diabetes Mellitus."

**Acting Director of Health Service.**—Dr. Homer L. Lawder, former practicing physician of Jerseyville, who has been assistant to the University health officer at the University of Illinois, Champaign, has been appointed acting director of the health service. In addition to serving as acting director of the health service, Dr. Lawder is an assistant professor of hygiene.

## COOK

**Society News.**—Dr. Raymond W. McNealy addressed the Greensboro Academy of Medicine, Greensboro, North Carolina, recently, on "Diagnosis and Management of Large Bowl Lesions."—Dr. Philip Thorek discussed "Biliary and Common Duct Surgery" before the Ingham County Medical Society in Lansing, Michigan, recently.—Dr. Edwin R. Levine addressed the Wyoming Tuberculosis and Health Association recently on "Today's Approach to the Tuberculosis Problem".

**Personal.**—Dr. Stanley W. Olson has been appointed by the University of Illinois Board of Trustees to the Board of Directors of the Institution for Tuberculosis Research.

Dr. Olson will fill a vacancy on the five-man board.

The personnel of the board now is composed of Drs. A. C. Ivy and Olson, appointed by the University; Drs. Herman N. Bundesen and Ernest E. Irons, appointed by the Board of the Municipal Tuberculosis Sanitarium of Chicago; and Dr. Walter H. Theobald, president of the Medical Center Commission, who was elected by the other members of the board.

The Institution for Tuberculosis Research was established by the 66th General Assembly of Illinois for the production, distribution, and application of the bacillus Calmette-Guerin (BCG), and other methods and materials for the prevention of tuberculosis and for conducting research in tuberculosis.—Dr. Pat S. Vitullo was recently named temporary chief surgeon of the police department succeeding Dr. Elmer W. Mosley, who resigned after holding the position since 1928.

**Specialty Society Election.**—Dr. Herman M. Soloway was elected president of the Chicago Urological Society at its annual meeting recently, succeeding Dr. James I. Farrell. Dr. Frederick Lloyd was chosen vice president and Dr. J. S. Grove, reelected secretary-treasurer.

**Dr. Kark Promoted.**—Dr. Robert M. Kark, chief of clinical investigation at the Army Medical Nutritional Laboratory, Chicago, has been appointed professor of medicine at the University of Illinois College of Medicine. The promotion was to be effective July 1.

He is interested primarily in metabolism and nutrition, and is the author with his colleagues of 57 scientific publications, mainly in the field of gastroenterology and hematology.

During the war, he was a member of a joint U. S. and Canadian research team which was responsible for improving army rations. He also served as consultant in medical research to the Canadian Army, and as head of a medical research unit for the Allied land forces in southeast Asia.

Born at Capetown, South Africa, Dr. Kark received his advanced education from the University of Capetown and from Guy's Hospital Medical School of the University of London. Prior to his appointment at the University, he served as a Rockefeller Traveling Fellow at the Thorndike Memorial Laboratory of the Boston City Hospital and the Harvard Medical School.

**Howard Shaughnessy Given New Post**—Appointment of Howard J. Shaughnessy, Ph.D., as professor and head of the newly-created department of public health at the University of Illinois College of Medicine was recently announced by Dr. A. C. Ivy, vice president.

Dr. Shaughnessy presently serves as chief of the division of laboratories of the State Department of Public Health, with offices at 1800 W. Fillmore St.

He assumed duties as head of the department of public health on June 1. He will continue to serve as director of laboratories of the State Department of Public Health, and thus will divide his time between the University and the Department.

With the establishment of the department of public health, the University will offer graduate instruction in the field of public health. Graduate students will have an opportunity to earn master of science degrees in such fields as public health laboratory.

Specialized courses for sanitarians and other public health groups will be offered. The University plans eventually to train specialists in such fields as public health administration, dentistry, health education, nursing, nutrition, laboratory practice, statistics, engineering, as well as epidemiology, tuberculosis control, venereal disease control, school health, industrial health, and sanitary science.

A program of research also will be undertaken by the department.

Dr. Ivy said that the department has been established "for the purpose of serving better the public health interests of residents of the state.

"Chicago, though it already ranks as the medical capital of the nation, is without a school of public health or a department offering extensive training in that field," he said. "No institution within 300 miles of Chicago operates a school of public health.

"This area offers outstanding advantages for public health training because of its access to industry located in a large metropolitan city, as well as the activities of nearby suburban communities and rural areas."

Dr. Shaughnessy has served as chief of the division of laboratories of the State Department of Public Health since 1930. He has been a member of the faculty of the University of Illinois College of Medicine since that date.

**Dr. Hoyne Honored.**—A testimonial dinner was held for Dr. Archibald L. Hoyne, June 1, and was attended by 200 of his medical friends and former students from all over Illinois, as well as other sections of the country. Dr. Karl A. Meyer was master of ceremonies, and speakers included Drs. Ernest E. Irons, Clifford G. Grulee, Joseph L. Crawford, John L. Reichert, Stanley Olson, Isaac Abt and Julius Hess. Dr. Hoyne was presented with a watch as a token of esteem.

**The Basil Harvey Fund.**—A group of Dr. B. C. H. Harvey's former students, colleagues, and friends have established The Basil Harvey Fund to honor his almost half-century of service to medical education. Dr. Harvey graduated at the University of Toronto College of Medicine in 1898, where he had previously been employed for a year as assistant in anatomy. Following three years in general practice he came to the University of Chicago and Rush Medical College in 1901 as assistant in anatomy. In 1917 he became professor in absentia while serving as major in France with the 13th Base Hospital (Presbyterian Hospital Unit). Dr. Harvey became Dean of Students in the Ogden Graduate School of Science in 1921, Dean of Medical Students in 1923, and Dean of Students in the Division of Biological Sciences in 1931. He retired in 1940, but returned to again serve in the last named position in 1943 during the Second World War, until his retirement at the age limit of 70 in 1944. The urgent need for a revolving loan fund for both undergraduate and postgraduate students of medicine provides a fitting purpose for this tribute to Dr. Harvey, who has always been vitally interested in the welfare of worthy students.

**Memorial Laboratory Dedicated.**—The Morris Fishbein Jr. Memorial Laboratory was dedicated at La Rabida Jackson Park Sanitarium recently. The laboratory is to be a new reserach center for study of rheumatic heart disease and was equipped by a fund established under the Chicago Heart Association to honor Morris Fishbein Jr. who died as a boy in 1929 of heart disease resulting from rheumatic fever. Dr. Hans Selye, director of the Institute of Experimental Medicine and Surgery, University of Montreal, made the dedication address, and Dr. N. C. Gilbert, past president of the Chicago Heart Association, a trustee of the memorial fund, presented the laboratory. It was accepted for La Rabida by Dr. Robert A. Black, trustee and emeritus chief of staff of the sanitarium. Richard J. Finnegan, editor of the Sun-Times and chairman of La Rabida's board of trustees, presided at the ceremonies. Other speakers were Dr. Hugh McCulloch, chief of staff at La Rabida, and Dr. Albert Dorfman, director of research, who is in active charge of the laboratory.

**Ground Broken For $14,000,000 V.A. Research Hospital.**—Ground was broken May 13 for the $14,000,000 television-equipped Veterans Administration Research Hospital which will become a part of the Northwestern University medical center on the near north side of Chicago. Designed to be one of the most modern and best equipped research hospitals in the world, the seventeen-story structure will occupy the entire block bounded by Huron

St., Fairbanks Ct., Erie St.,and McClurg Ct. Construction work is expected to require about twenty months. Presiding was Dr. Richard H. Young, dean, Northwestern University Medical School and addresses were made by Maj. Gen. Carl R. Gray, Jr., administrator of veterans affairs, and Dr. J. Roscoe Miller, president of Northwestern University.

From the standpoint of design, equipment and operation, the new hospital will be one of the finest and most modern institutions of its type in the world. It will have a capacity of 529 beds and will have facilities to care for 30,000 visits annually by patients receiving diagnosis and medical attention and not requiring hospitalization. There will be accommodations for 90 nurses and 50 resident interns and research workers.

The Veterans Administration and Northwestern's Medical School will work together in operating the hospital. A committee consisting of Dr. Young and a number of the school's department heads, will serve as consultants, assisting in the medical supervision and staffing of the hospital.

Addition of the new hospital to Northwestern's Medical Center will make this center one of the foremost in the country for medical training, research, diagnostic work and treatment.

Equipment costing approximately $2,000,000 will be installed in the new hospital, including portable television cameras for three operating rooms with outlets to classrooms, lecture rooms and the assembly room. All necessary television conduits are to be installed in the structure so the hospital will be ready to use color television for medical training.

X-ray equipment for the new hospital will represent the largest massing of this type of facilities in any Veterans Administration hospital in the country. This equipment will occupy the entire second floor.

Perhaps the most spectacular piece of equipment will be a $200,000 atom-smashing betatron which will be used not only for research work but in direct treatment of malignant diseases. Patients with cancer will be treated with rays from radio-active material, the most modern method of combating this disease. The betatron will be housed in the second sub-basement.

Another feature of the hospital is the research facilities which will occupy two entire floors, the seventh and eighth. The clinical laboratories will be on the seventh floor and the research laboratories on the eighth, with the latter including complete facilities for experimental work with animals.

## EFFINGHAM

**Health Officer Resigns.**—Dr. Fred O. Tonney, director of the Effingham-Shelby bi-county health department, has resigned, effective May 31. He has held the position for two years.

## HANCOCK

**Hospital of the Month.**—The Hancock County Memorial Hospital, Carthage, was recently named the "Modern Hospital of the Month" by the magazine, Modern Hospital, which plans to run a series of articles on hospitals being constructed throughout the country. The Carthage hospital, still under construction, was being built with grant-in-aid funds of the hospital construction program. Begun last July, this fifty-bed, $732,568 hospital will be ready this fall.

## KNOX

**Society News.**—A film on "Appendicitis in Childhood" was a feature of the regular monthly meeting of the Knox County Medical Society, May 18, at the Galesburg Club according to Lowell C. Neveln, secretary of the public relations committee of the society.

## MACON

**Society News.**—Dr. Robert J. Mueller, assistant in neuropsychiatry, Washington University School of Medicine, St. Louis, addressed the Macon County Medical Society May 16 on "Principles of Psychosomatic Medicine."

## ROCK ISLAND

**Surgeons Choose Officers.**—Dr. Clement P. O'Neill, Rock Island, was elected president of the Rock Island county and regional district of the American College of Surgeons at an organization meeting in Moline Public Hospital, May 4. The district includes Rock Island, Mercer, Henderson and Henry counties. Other officers are Dr. Louis D. Barding, East Moline, vice president; Dr. R. D. Perkins, Moline, secretary; and Drs. Louis Arp and F. J. Otis, both of Moline, and H. P. Miller, Rock Island, council members. The group plans to meet quarterly.

## WINNEBAGO

**Annual Clinic Day.**—May 10 was the Annual Clinic Day at St. Anthony Hospital. The program was presented by the following: Dr. George Rezek, associate professor of obstetrics and gynecology, Illinois Research Hospital, "Particular Aspects of Endocrinology"; Dr. Joseph Pratt, "Acute Appendix and Allied Conditions"; Dr. W. H. Williams, chief, eye, ear, nose and throat department of Mayo Clinic, "Medical Treatment of Allergies and Physical Allergy"; Dr. George Byfield, clinical associate of medicine, University of Illinois College of Medicine, "Hypertension" and Dr. Eugene Traut, associate professor of medicine, University of Illinois College of Medicine, "Concepts of Treatment and Diagnosis of Joint Diseases."

## HEALTH DEPARTMENT ACTIVITIES

**Report on Typhoid.**—Dr. Roland R. Cross, state director of public health, recently stated that the new low in typhoid fever mortality in Illinois last year was "a most remarkable development in modern public health."

Only one death from typhoid fever was recorded last year as compared to as many as 33 in 1940. As late as 1921, nearly 400 persons died from typhoid, while at the turn of the century nearly 2,000 persons were being killed by this disease annually.

"The decline of typhoid fever reflects personal cleanliness and household and community sanita-

tion," Dr. Cross declared. "Thus, the practical obliteration of typhoid is primarily due to personal behavior and community sanitation rather than to advances in treatment procedures as is the case in most diseases."

The only way in which typhoid fever can be contracted is by the germs entering the body through the mouth. Epidemics of the past have been traced directly to contaminated water, milk or food.

"All of our typhoid epidemics have been found to stem from filthy conditions," Dr. Cross asserted, "The near-eradication of the disease dramatically points to the fact that most of the unsanitary conditions of other years no longer exist in this state."

He praised the activities of local groups which have demanded purification of public water supplies, pasteurization of milk and treatment of sewage. He declared that these activities are responsible for much of the progress against typhoid.

The work of the "typhoid sleuths" who trace every case of this disease to a definite source was applauded by Dr. Cross. By finding the point of origin of the typhoid germs, sources of human infection can be substantially reduced.

Practically all, if not all, of the cases which now occur in Illinois are traced directly to typhoid carriers, he added. These persons, as soon as they are discovered, are required to follow practices which will insure that they do not pass the infection to other people.

The state health department now keeps track of 452 carriers of typhoid and para-typhoid fever who reside in Illinois. Through full-time city, county and district health officers, a constant vigil is kept on the carriers to see that they keep faith with the regulations which are necessary to safeguard public health.

**Mortality Report for 1949.**—Deaths from all causes in Illinois last year totaled 90,971, according to provisional statistics for 1949 recently released by the state Division of Vital Statistics.

The total represented a rate of 10.8 deaths per 1,000 population, the same rate as existed in 1948 when 89,863 deaths were reported.

Dr. O. K. Sagen, chief of the Division of Vital Statistics, said that this death rate shows a favorable trend when it is remembered that in Illinois there are "increasing numbers of persons in advanced years."

In general, the cause of deaths in 1949 followed the pattern of 1948, Dr. Sagen pointed out.

Heart disease was again the leading fatal agent, being responsible for 34,713 deaths. This total is greater than the number of deaths from the next five causes.

Other leading causes of death were cancer, 13,926 deaths; cerebral hemorrhage, 7,112; all accidents, 5,030; nephritis, 4,808; diabetes, 2,887; influenza and pneumonia, 2,840; tuberculosis, 2,449; premature birth, 1,864 and arteriosclerosis, 1,500.

All communicable diseases caused a total of 6,400 deaths as compared with 6,322 of 1948. Polio deaths totaling 231 were the highest in Illinois history.

Two deaths from rabies and from scarlet fever, the first in both instances to be reported since 1946, occurred last year.

For the 11th consecutive year there was no death from smallpox. Not a single case of smallpox was reported in 1949, for the second straight year.

## GENERAL

**Award for Outstanding Research in the Field of Infertility.**—The American Society for the Study of Sterility offers an annual award of $1000 known as the Ortho Award, for an outstanding contribution to the subject of infertility and sterility. Competition is open to those in clinical practice as well as individuals whose work is restricted to research in the basic sciences. Essays submitted for the 1951 contest must be received not later than March 1, 1951. The prize essay will appear on the program of the 1951 meeting of the society. For full particulars, address The American Society for the Study of Sterility, 20 Magnolia Terrace, Springfield, Mass.

**Meeting of Health Officers.**—At the Spring meeting of the Illinois Association of Medical Health Officers held recently in Springfield, Illinois in conjunction with the Annual Meeting of the Illinois Public Health Association, the following officers were elected for the coming year of 1950-51. They are the President, Dr. S. N. Mallison, Health Officers in charge of District Health Office #6, Champaign, Illinois; the Vice-President, Dr. L. L. Fatherree, Health Officer in charge of the Will County Health Department, Joliet, Illinois; and the Secretary-Treasurer, Dr. Herbert Ratner, Health Commissioner of Oak Park, Illinois. Dr. W. H. Tucker, Health Commissioner of Evanston, Illinois was elected to the Executive Committee.

The Illinois Association of Medical Health Officers consists of full-time medical public health personnel of the State, District, County, and Municipal Health Departments, and physicians on a full-time basis as teachers of public health or in school health services. The purpose of the organization is to further health practices, to consider questions relating to practical administration of public health, hygiene and sanitation, to provide consultation to State and local public health agencies, to make recommendations regarding standards, rules and regulations, and to undertake such other functions as will promote better public health organization in the State of Illinois.

## MARRIAGES

Dr. Wesley L. Peterson Jr., to Miss Joan M. Cook, both of Oak Park, recently.

Dr. J. A. Mathis, to Miss Ann Bishof, both of Pinckneyville, on June 1.

## DEATHS

Nora F. B. Brandenburg, Winnetka, who graduated at the University of Illinois College of Medicine in 1926, died June 1, aged 50.

Clarence F. G. Brown, Chicago, who graduated at Rush Medical College in 1924, died June 4, aged 52. He was senior attending physician at St. Luke's Hospital since 1925, and assistant professor of medicine at Northwestern University Medical School.

Homer S. Corley, retired, Tower Hill, who graduated at Missouri Medical College, St. Louis, in 1897, died May 24, aged 78. He had practiced medicine in Tower Hill over 50 years.

Harry S. Gradle, retired, Chicago, who graduated at Rush Medical College in 1908, died recently in California, aged 67. He was professor of ophthalmology (Emeritus) at (Rush) University of Illinois College of Medicine, and chief of staff, (Emeritus) of the Illinois Eye and Ear Infirmary.

James E. Gregory, formerly of Crossville and Maunie, who graduated at Chicago College of Medicine and Surgery in 1915, died at McComb, Miss., May 12, aged 64.

Frederick C. Hamilton, retired, Kankakee, who graduated at Northwestern University Medical School in 1893, died June 4, aged 79. He had practiced medicine in Kankakee for 49 years.

John Herbert Kincaid, Sr., retired, formerly of Chicago, who graduated at the University of Illinois College of Medicine in 1903, died in Manitowoc, Wis., June 1, aged 79.

Eugene T. Leonard, Rockford, who graduated at Rush Medical College in 1915, died May 4, aged 60. He had practiced medicine in Rockford for 33 years and for the last 27 years had been a member of the Staff at St. Anthony Hospital.

Julian D. Levinson, Chicago, who graduated at Northwestern University Medical School in 1946, died June 2, aged 27.

Andrew D. Miller, Sullivan, who graduated at Missouri Medical College in St. Louis, 1891, died recently, aged 85.

S. Frank Russell, Macomb, who graduated at Rush Medical College in 1901, died May 9, aged 73.

Clark E. Weir, Abingdon, who graduated at St. Louis University School of Medicine in 1906, died May 23, aged 70.

James H. Welch, retired, Rockport, who graduated at Hospital College of Medicine, Louisville, Ky., in 1891, died May 20, aged 81.

Wilson H. Whitsitt, retired, Danforth, who graduated at Rush Medical College in 1901, died May 30, aged 78.

Wilbur C. Wood, Decatur, who graduated at Northwestern University Medical School in 1895, died May 6, aged 84. He was a member of the Illinois State Medical Society "Fifty Year" Club.

Charles W. Wren, Sr., who graduated at Meharry Medical College, Nashville, Tenn., in 1915, died May 19, aged 61.

Frank J. Zuehlke, Chicago, who graduated at Bennett Medical College in 1910, died March 14, aged 63.

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## THE PHYSICIAN—A PUBLIC SPIRITED CITIZEN

. . . I often wonder, as a layman, whether the doctors, sometimes in spite of their deep conviction against socialized medicine. may not be helping to promote it. I think of a city, for example, where there is great need for an additional hospital facility, for pay patients. It would be a difficult task, I am sure, to raise the millions that would be required to build even a half-way adequate hospital. Yet I am very sure in my own mind that the creeping spread of socialism will be aided if that community takes the easy course of calling upon its local and federal government to build that hospital out of public funds.

How much better for the business men and the doctors of that community if they would face up to the problem, and organize to raise the money for this enterprise from private subscription and donation, just as they do for their Community Chest! The community can far better afford to pay for its own, in this way, leaving the hospital in the hands of competent medical men to administer, than to have the local public officials build it and then place it under political management. *Excerpt: The Doctor and His Community, Mr. William H. Book, Indianapolis, executive vice-president, Indianapolis Chamber of Commerce and president, American Chamber of Commerce Executives; The Journal of the Indiana State Medical Association, May, 1950.*

# "FOR THE COMMON GOOD"

**Health Talk on WGN-TV.**—With the advent of the baseball season, Health Talk is scheduled only on those Monday's when a game is not held in Chicago. Since the last issue of the Illinois Medical Journal, the following telecasts have been presented:

Your Baby's Routine Physical Checkup May 15, Harry Leichenger and August Daro, and Moulton and Sylvia Kelsey with their baby, Susan Valentine.

What Can the Diabetic Do, May 22, Henry T. Ricketts and Alvah L. Newcomb, with adults and children portraying their routine in carrying on a normal life.

Pages from Medical History, May 29, Samuel J. Zakon, Elizabeth Carr and Georgia Price, all of Northwestern University Medical School, displaying historical items in literature and equipment.

The Student Nurse at Work, June 12, with Dr. Arthur K. Peterson, medical director of R. R. Donnelly and Sons Company as moderator; other participants were Mrs. Helen Harris, R. N., Michael Reese Hospital; Shirley Gillund, St. Luke's Hospital; Hans Mauksch, University of Illinois; Miss Shirley Keyworth, St. Anne's Hospital; Miss Ruth Gustafson, R. N., Lutheran Deaconness; Mrs. Thelma Clinie, R. N., public health; Miss Ethel Swanson, R. N., Naval Hospital, Great Lakes; Miss Harriet Blaine, R. N., Fifth Army; Marian Etten, Stritch School of Medicine.

Your Eyes Tell a Story, June 19, Edward Webb, Henrotin Hospital, and W. W. Bolton of the American Medical Association.

## RADIO

**Your Doctor Speaks** over FM Station WFJL carried the following physicians in transcribed talks:

Leo Kaplan, June 1, Alcoholism.

Edwin N. Irons, June 8, The Newer Antibiotics.

Robert G. Kesel, D.D.S., Tooth Decay, June 15.

Armand J. Mauzey, June 22, Obstetric Facts.

At the request of Radio Stations WCFL and WAAF, the Educational Committee is arranging a series of popular talks on health. The series on WCFL is being planned on a forum type discussion, with the guest physician; Dr. James P. Shortall appearing as Medical Director of the Chicago Federation of Labor, and a studio announcer participating in the transcribed broadcast. The series will open August 1 with Dr. William P. Swisher on "Why A Case History." On August 8, Dr. Richard Bennett Jr., presented "Hernias."

The series on WAAF, which began July 11, is designed to carry on informal discussions on prenatal and pediatric care, stemming from the idea of Del Hester, program director of WAAF, and Judy Logan, former staff announcer. The series on pediatrics is one in a daily program titled "Here's the Story" and will be called "You and Your Baby." Dr. George Vlasis, staff member of the Chicago Maternity Center, opened the series with a discussion on prenatal care, and Dr. Charles Krause, instructor in obstetrics and gynecology, appeared July 18, on the mother's last office visit and the delivery of the baby. On July 25, Dr. Alvah L. Newcomb, president of the Chicago Pediatric Society, will discuss the pediatric care in the hospital.

The WAAF programs are "live" shows and have the full cooperation of the Chicago Pediatric Society. The Secretary of the Educational Committee will also participate in the role of interrogator.

## CREDITS

The ever increasing interest in matters of health is evidenced by the cooperation of radio and television stations. To Jay Faraghan, program director of WGN-TV goes credit for launching Health Talk Dec. 15, 1948 as a public service; Jim Ameche program director of FM Station WFJL, for inaugurating "Your Doctor Speaks" Feb. 7, 1950; Del Hester, program director of WAAF, for creating "You and Your Baby", July 11, and July 15 Frank McGivran, publicity director of WCFL, for starting "Here is Your Doctor."

*Lectures Arranged Through the Educational Committee*:

Eugene L. Slotkowski, Chicago, Sheridan Road Preschool Nursery, June 5, on Growing With Your Child.

James H. Hutton, Chicago, June 13, Woman's Auxiliary of St. Mary of Nazareth Hospital in Hinsdale, June 13, on Obesity.

Robert R. Mustell, Health Education Committee at the YMCA in Chicago, June 19, on The Need for a Vacation.

Edward Press, Chicago, Bureau County Tuberculosis and Bureau County Health Council, June 19, in Princeton, on Health Service for the School Child.

*Lectures Arranged Through the Scientific Service Committee*:

Hermann W. Wellmerling, Bloomington, Macoupin-Montgomery County Medical Societies in Carlinville, July 25, on General Fractures.

Edward L. Compere, Chicago, Whiteside-Lee County Medical Societies, September 7, Fractures of the Hip, Leg and Shoulder.

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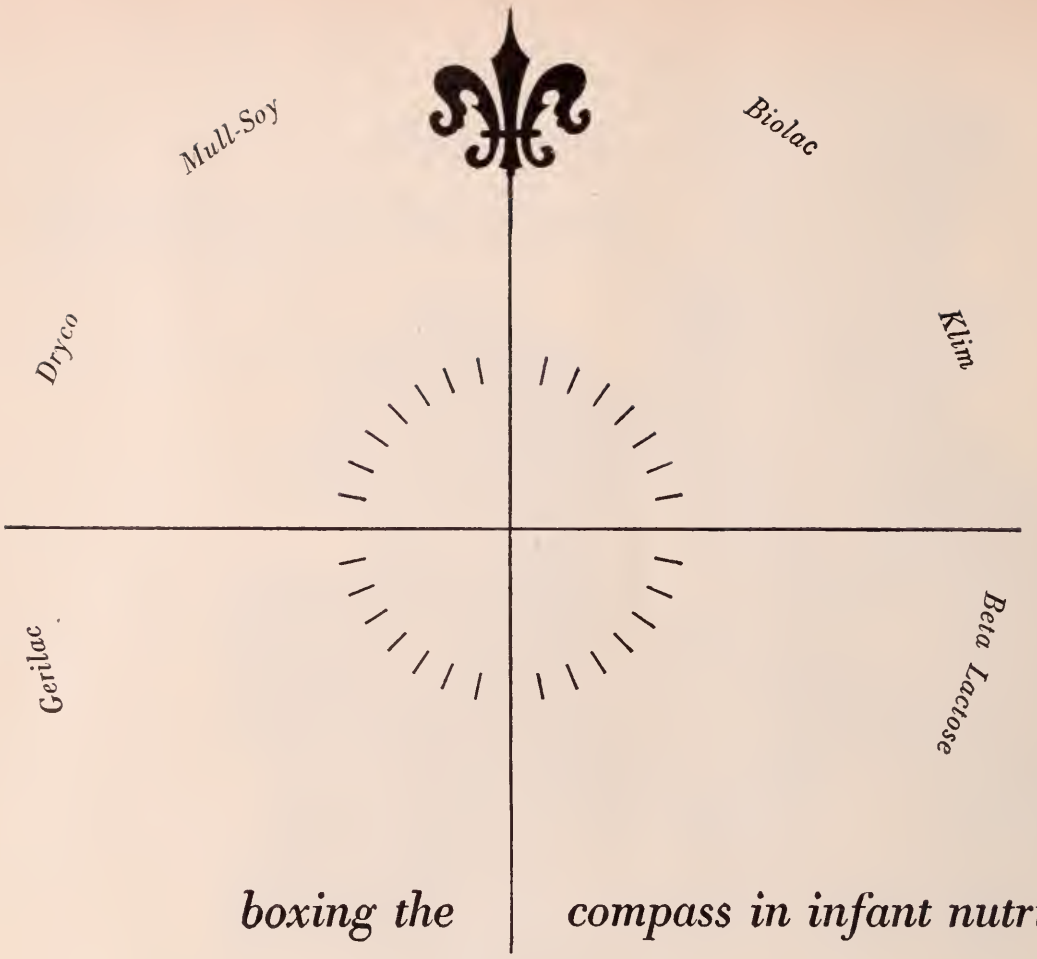
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1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.

2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.




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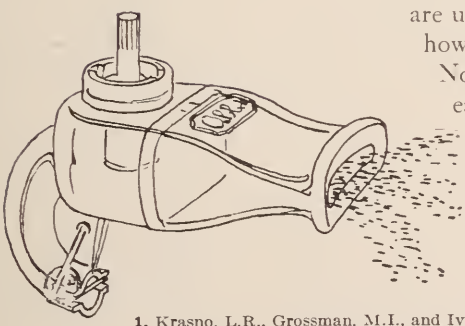
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1. Krasno, L.R., Grossman, M.I., and Ivy, A.C. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March. 2. Krasno, L.R., Grossman, M., and Ivy, A.C. (1948), The Inhalation of Norisodrine Sulfate Dust, Science, 108:476, Oct. 29.

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# PHYSICAL MEDICINE ABSTRACTS



## SYSTEMIC THERMOTHERAPY: WITH SPECIAL REFERENCE TO HOT-AIR BATHS

Victor R. Ott, M.D., Zurich, Zwitzerland. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 13:1:9, January 1950.

It is not possible to discuss in this paper details of all the forms of systemic heat treatment; I shall only try to illustrate some of its problems by using the example of a special type of general thermotherapy, which is different from pyrexial treatments of a duration of many hours. Some observations and results in this special case will help us to understand better the general basis of systemic thermo-therapy in all its forms.

Apart from warm water and from the radiant heat emitted by a fire, hot air is probably the oldest means of heating the human body; certainly, it also has been applied in treatment of sick men since ancient times. Yet, during a long period, the scientific basis of this therapeutic procedure did not find much interest on the part of the medical profession, although the basic problems had been clearly realized as long as 174 years ago, as is shown by the outstanding papers which Charles Blagden published in the *Philosophical Transactions of the Royal Society* in the year 1775.

With reference to his investigations on the Finnish hot-air bath, the author discusses the physiological and patho-physiological bases of systemic heat treatment (omitting the direct thermal action of long-lasting hyperthermy upon pathogenic micro-organisms). The most important aspect of the physiological egects of systemic heat treatment is its influence upon the tonic level of the whole autonomic nervous system — no only of the sympathetic or parasympthetic alone: that is to say, that an "amphotonic" autonomic reatcion is produced by physical hyperthermy.
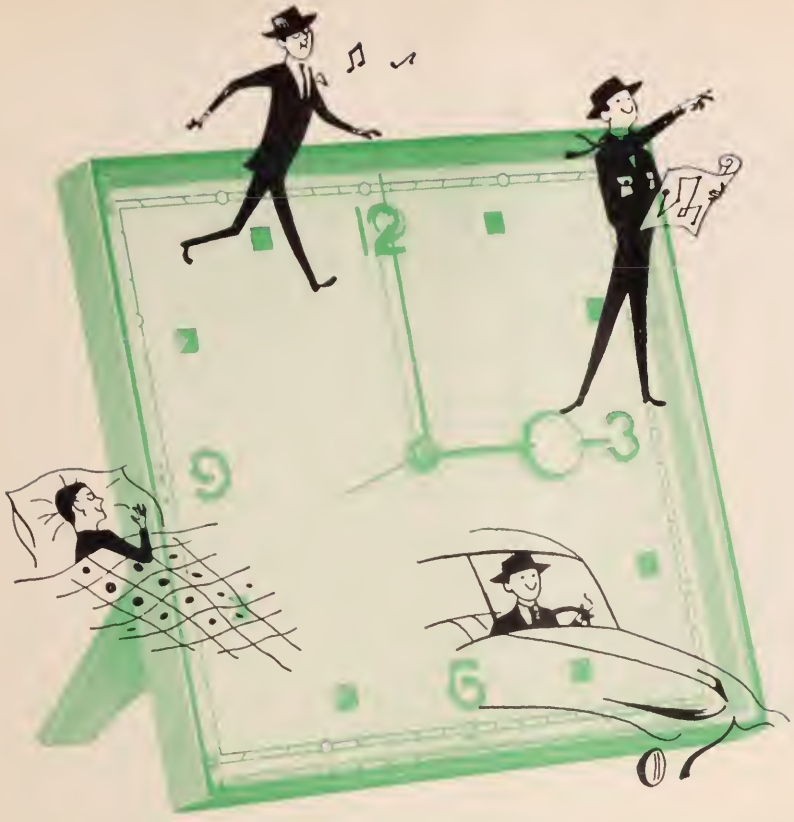
This theory explains the well-known fact that the individual condition of the patient is broadly decisive in regard to the effects of systemic physical treatments; it also explains the many contradictions of experimental observations of different functions and in different patients. Furthermore, the theory allows us to establish the therapeutic indications on a secure and rational basis.

## BASIC PRINCIPLES IN THE DIAGNOSIS AND TREATMENT OF FRACTURES

Allen F. Voshell, M.D., Baltimore, Md. In AMERICAN PRACTITIONER, 1:1:8, January 1950.

Although there have been many advances and changes in the methods of treating fractures due to the development of newer metals and appliances, chemicals and drugs, etc., the problem still is one of reducing and immobilizing the bone fragments until sufficient union takes place to allow the use of physical and occupational rehabilitation. The bones and joints of our fore-

(*Continued on page* 44)



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1. "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—"... Sheldon, J.M. Et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948)
2. "It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—" ... MacQuiddy, E.L.: Neb. State M.J. 34:123 (1940)

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## Physical Medicine (Continued)

bears were of the same type and character as ours, and nothing has altered the basic anatomic and physiologic features of these structures or the changes incident to injury or disease. The newer means and wider range of travel, the use of more machinery, etc., in brief, the more complex and intricate existence of human beings these days, have caused the development of many more of the severer types of injury, such as comminuted and compound fractures, but a very great number of fractures still are due to falls, and leverage forces of various kinds. In consequence, I do not feel any hesitancy in discussing features of diagnosis and treatment of apparently elementary and fundamental character based on the mechanics of anatomy and the physiologic changes of development. Experience shows that too much dependence is being placed upon gadgets and machinery in the care of fractures and not enough on conservative, sound brain work and an understanding analysis of the whole problem; the latter includes the patient, the mechanics of the cause of fracture, the simplest treatment method consistent with the best result in the end with least risk and loss of time, early use of physical and occupational therapy, psychologic, social and economic adjustment, and similar factors.

### SQUARE DANCING FOR THE HANDICAPPED

Ed Durlacher. In THE CRIPPLED CHILD, 27:5:16, February 1950.

The general public, excluding the inner circle of square dance devotees, is not aware that dances are scheduled for nearly every evening in the parks, clubs or recreation centers of most cities, and that square dances are regular weekend entertainment in many rural areas.

The public is still less aware that instructors have successfully taught square dancing to widely diversified groups of handicapped persons, with results gratifying to all concerned. Although methods and procedures used are too new to have become standardized as yet, certain instructions and the resultant success of the dancers indicate these methods may be profitably used by other recreation directors who deal with the handicapped.

We have worked always with a basic premise, "What can square dancing do for the people?"

(*Continued on page* 46)



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while teaching square dancers and instructors throughout the country. Some of our pupils have been amputees confined to wheelchairs; psychoneurotic and other mental cases; the cerebral palsied; the deaf and dumb; as well as the blind.

Handicapped persons prove to be interested and willing pupils — rarely does one meet a group for which some teaching technic cannot be adapted.

Whether square dancers on ice, roller skates, or horseback, handicapped, or not handicapped, old or young, theirs is a recreation that gives back far than it demands, providing wholesome fun and exercise for all who will participate. Because it is a group activity, it stimulates cooperation, and many of us have come to realize that we help ourselves best when we are helping others. Understanding the other fellow's problem will help the individual understand and solve his own — to the tune of toe-tickling music and the rapid square dance parlance that follows when the caller says: "Honor your partner!"

## TREATMENT OF POLIOMYELITIS

Earl C. Elkins, M.D., Rochester, Minn. In KENTUCKY MEDICAL JOURNAL, 48:3:136, March 1950.

The concept of treatment of poliomyelitis is now fairly well established, although technic varies in minor ways. The major aim of active treatment of poliomyelitis is to salvage what remains of the function of the weak and paralyzed muscles. None of the treatments used, for example, supportive, physical, or orthopedic treatment, has any effect on the progress of the disease; nor can treatment change the already existing primary lesions in the central nervous system.

During the past decade, because of an apparent increase in incidence of the disease, and an undoubted increase in accuracy of diagnosis, interest in treatment has been augmented. It is evident, however, that not enough physicians in widely scattered, small hospitals are prepared to organize and supervise treatment through all phases of the disease. In many epidemic areas, where emergency technical help has been allo-

(*Continued on page* 48)


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cated, this personnel has been expected to examine patients and to evaluate and prescribe treatment for the neuromuscular involvement in a large percentage of cases. Medical supervision often has been superficial and has consisted of irregular visits of a physician from a distant center.

The clinical phases of poliomyelitis usually are divided into three stages: acute, convalescent and chronic. In treatment of acute poliomyelitis, supportive measures are those used in any infectious disease. Emergency procedures, moreover, sometimes are necessary to save the patient's life. In this connection careful observation of the patient for respiratory difficulty is important.

*Physical Support.*—Measures should be taken, in cases in which paralysis is present, to provide proper support of the extremities and to maintain correct bodily alignment. Rigid supports may be used but not as substitutes for good care.

*Heat.*—The mechanism by which frequently applied hot packs relieve the pain of poliomyelitis and cause muscular relaxation is not known. Neither is it known whether the moist heat of the hot pack has any advantage over other forms of heat. The method of applying packs has changed considerably. The meticulous procedure of applying hot packs to the various segments of the body is not as widely used now as previously. In the past several years, use has been made of the so-called prone pack although the patient may be either prone or supine. At all events, in the majority of cases of poliomyelitis, if proper treatment is given, the pain, tenderness and muscular tightness usually disappear in two to eight weeks. It should be recognized, however, that in many instances heat alone will not eradicate the muscular tightness.

*Stretching*:—Passive stretching exercises, if carefully done following thermotherapy, are important. As the pain subsides, stretching can be continued until the muscle tends to remain supple and at full length. After the painful stage of the disease is past, the muscle apparently can be carefully but rather strenuously stretched, without danger of injury.

*Stage of Convalescence*: Treatment after the acute stage (fourteen to twenty-one days), in ad-

(*Continued on page* 52)

| | Calories | Protein Gm. | Calcium Gm. | Copper mg. | Iron mg. | Phosphorus Gm. | Vitamin A I. U. | Thiamine mg. | Riboflavin mg. | Niacin mg. | Ascorbic Acid mg. | Vitamin D I. U. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Research Council Allowances, Sedentary Man (154 lbs.) | 2,400 | 70 | 1.0 | 1.2 | 12 | 1.5 | 5,000 | 1.2 | 1.8 | 12 | 75 | Small Amount |
| Ovaltine in Milk, 3 Servings* | 676 | 32 | 1.12 | 0.5 | 12 | 0.94 | 3,000 | 1.16 | 2.0 | 6.8 | 30 | 417 |
| Percentages of N. R. C. Allowances Provided by 3 Servings* of Ovaltine in Milk | 28% | 46% | 112% | 42% | 100% | 63% | 60% | 97% | 111% | 57% | 40% | Abundance |

*Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk.

# Supplementation

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The aim of the dietary at all times and under all conditions is to provide ample amounts—not just minimum amounts—of all nutrient essentials. Only when the daily nutrient intake is fully adequate, based on the most authoritative nutritional criteria, can the possibility of adequate nutrition be assured. It is for this reason that a food supplement assumes great importance in daily practice. It should be rich in those nutrients most likely deficient in prevailing diets or in restricted diets during illness and convalescence.

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Note in particular the high percentages of the dietary allowances for nutrients and the relatively low percentage of the total calories furnished by the servings of Ovaltine in milk. Thus, without unduly increasing the caloric intake, Ovaltine in milk greatly increases the contribution of nutrient essentials. Enticing flavor and easy digestibility are other important features of this dietary supplement.




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dition to attempting to relieve pain and muscular tightness, should have as its aim the establishment of coordinated muscular function. It is in this phase of treatment that the greatest strides have been made.

Training of patients to coordinate movements is done largely by stimulation, through careful passive motion, of proprioceptive nerve endings in the various muscles. Training periods are frequent and the muscles are pointed out to the patient. Passive motions are carefully guided, and active motions assist in establishing the coordinated patterns of movement.

Training of the patient in coordinated movements in such a manner that all groups of muscles function to the best advantage, and so that weak muscles are used and developed properly, requires special skill on the part of the physical therapist and careful observation and judgment on the part of the attending physician. Weeks or months may be required, and to decide whether maximal benefits have been reached may be difficult.

*Muscular Strength*:—Methods used do not differ greatly from those which have been employed for many years. However, compared with former times, more emphasis has been placed on this training and it is carried on for a longer period. First, weak and paralyzed muscles are carefully and passively tugged to establish a proprioceptive sense. Then, as voluntary control returns, active exercise of individual muscles or of groups of muscles is instituted. The amount of exercise is increased as muscular power increases; that is, from movement with assistance, to movement with the force of gravity eliminated, and then to movement against both the force of gravity and resistance.

*Activity*:—As muscular strength returns and coordinated motion is established, the activities of the patient are increased.

*Rehabilitation*:—In training a patient who has extensive poliomyelitis, it is necessary to bear in mind that, in addition to trying to increase muscular strength and bring about the best possible function of the remaining muscles, the patient must be physically rehabilitated to the greatest possible degree. Frequently little or no guidance is given the patient relative to his fu-

(*Continued on page* 52)



# RELAX THAT SPASM with MESOPIN

When pain, heartburn, belching, nausea, or unstable colon are due to gastrointestinal spasm, Mesopin provides an effective means for prompt relief. Its selective antispasmodic action on the digestive tract controls spasticity without the undesirable side effects of atropine or belladonna. Thus, symptomatic relief of many common disturbances of the stomach or intestines can be achieved with discrimination and safety. Mesopin is indicated for the relief of gastrointestinal spasticity, such as pylorospasm, cardiospasm, spastic colon, and biliary spasm.

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*PB abbreviated designation for phenobarbital.

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ture life. This is left to the family or to a social agency. These patients must be treated as a whole, as any severely handicapped patient is treated, and treatment can be considered a partial failure if this is not done. The patient's family, in most instances, cannot adequately finish rehabilitation of the patient.

*Chronic Stage*:—Poliomyelitis usually is considered to have become chronic after recovery from weakness or paralysis has ceased.

The final stage of treatment consists of (1) permanent use of orthopedic appliances, (2) correction of deformities and production of stabilization by surgical means.

Finally, treatment during the chronic stage—and the same is true of the convalescent stage—should be supervised from the beginning by a team of workers skilled in treatment of musculoskeletal disease in general, and of poliomyelitis in particular.

The late stages of poliomyelitis present an extremely variable problem: physical, social and economic. Treatment must be highly individualized and adapted to the patient's needs.

## PROBLEMS OF INSTITUTIONAL CARE OF THE AGED

David A. Boyd, Jr., M.D., Rochester, Minn. In THE AMERICAN JOURNAL OF PSYCHIATRY, 106:8:616, February 1950.

The improvements in living conditions and medical care have lengthened the average span of human life. Each year a greater percentage of the population reaches advanced ages, and statistics indicate that this trend will be maintained. Thus there are ever-increasing numbers liable to degenerative changes, especially in the central nervous system. If the impairmen is sufficient to produce serious mood disorder, paranoid delusional systems, advanced deterioration, or difficult behavior problems, the patient is usually admitted to a psychiatric hospital. There is no question that such patients need and deserve the treatment and protection that is

(*Continued on page* 54)

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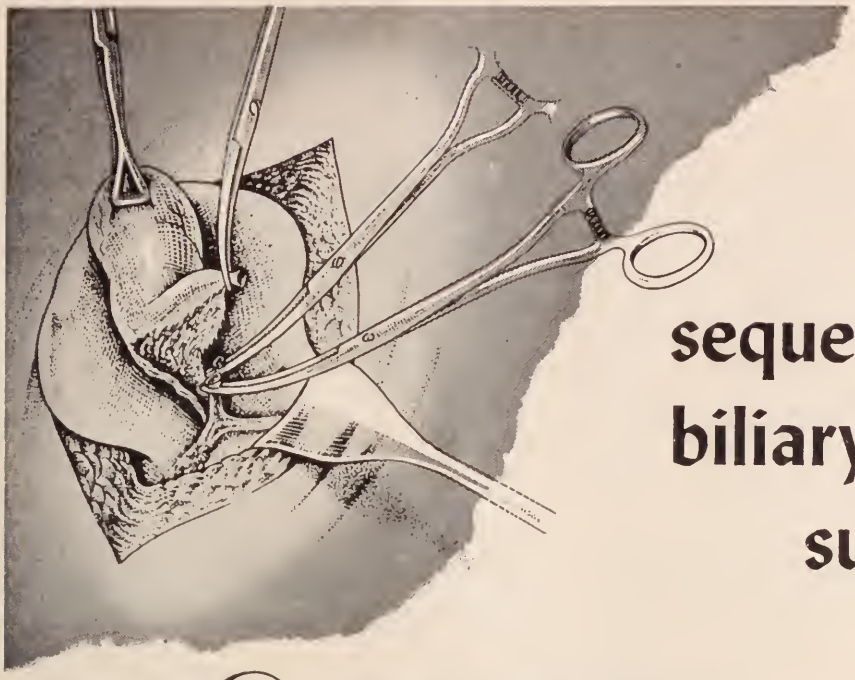
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provides an effective means of flushing out the biliary tract. Used together with antispasmodics such as atropine and nitroglycerin, *Decholin* helps to remove blood clots, residual debris and hidden, small calculi. This method, recently re-emphasized by Best,[1] is useful with or without T tube drainage. In reflex biliary stasis, *Decholin* serves to prompt an adequate secretion of bile.

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1. Best, R. R.: Ann. Surg. 128: 348 (Sept.) 1948.

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provided only by a hospital setting. However, the majority of elderly patients will have only mild memory defects and the general deterioration of aging. Their medical care and disposition present complicated problems that are not solved adequately at present either by the community or the psychiatric hospitals. Even greater problems are to be expected in the future as this group increases unless a carefully considered program for their care is formulated. This discussion is concerned primarily with the elderly patient whose outstanding disability is simple deterioration without disturbed behavior or major psychopathologic trends.

The present methods of managing the problems of the aged have proved unsatisfactory and inadequate. Common humanity demands the formulation of some program of care that permits the elderly to maintain dignity, self-respect, and a sense of worth as well as providing physical necessities. This can be accomplished by state institutions designed to provide a program of activities and care suited to the needs and abilities of an aged resident population. In the long run, the total cost of such care will be no greater than the present wasteful and haphazard types of custodial management. In addition, it will permit this ever larger group to spend their declining years in a setting that encourages a sense of personal dignity and utilizes their skills. It has been said, "Three score and ten years make the upshot of man's pleasurable existence." This does not have to be so if the problem is met carefully by planning and new approaches. Not only will the lives of the aged be enriched, but the public mental hospitals will be enabled to return to their primary function of treating the mentally ill.

---

The increase in facilities for distribution of necessary food, the more widely spread knowledge of the principles of healthful living, better understanding of good housing and the leveling off of income, with few rich and few poor, have been, and will continue to be, important factors in the prevention of incidence of and death from tuberculosis. Unless a world-wide catastrophe interferes, it seems clear that social factors will continue to favor reduction rather than increase of tuberculosis. W. G. Smillie, M.D., New England J. Med., January 12, 1950.


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# BOOK REVIEWS



Diseases Of The Foot: By Emil D. W. Hauser, M.S., M.D., Associate Professor of Bone and Joint Surgery, Northwestern University Medical School. New, Second Edition. 415 pages with 195 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $7.00.

The author has revised and rewritten to a considerable extent, this second volume of a book previously very popular. Greatest consideration in functional disturbances of the foot remains its function as it has been in the past. The author again presents the anatomy of the foot in minute detail, along with the physiology of this important extremity. He likewise discusses the hygiene and general care of the feet.

Then in turn, the orthopedic disturbances, postural disturbances and arthrosis of the various structures comprising the foot. A considerable amount of space is devoted to consideration of the circulatory disturbances. During and following World War II, definite advances have been made in the management of these disturbances, which are given in this section.

Infections and the many disturbances of the feet are carefully discussed in the book, as well as sprains, fractures and dislocations. The book is well illustrated, many of these new and likewise timely. The fine illustrations do add materially to the value of the book to the average reader.

The book should be a must in the modern medical library and once more it is predicted that this second edition will be as popular as the first one published in 1939.

---

Current Therapy 1950 — Latest Approved Methods Treatment for the Practicing Physician — Editor: Howard F. Conn, M.D. Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 736 pages. Philadelphia and London: W. B. Saunders Company, 1950. Price $10.00.

Twelve consulting editors assisted in the preparation of this unusual book on therapy, and more than 250 prominent members of the medical profession were contributors.

The contributors were selected carefully and each section has been written by one well versed with the subject under discussion. In many instances, especially on subjects of a controversial nature, the methods of two or three different contributors are given, which adds materially to the interest of the subject being presented.

The book covers well the major ailments of the various organs and structures of the human body and each article is written clearly and obviously for the general practitioner, to give the up to the minute preference in the form of therapy for these many ailments.

This is a well arranged and well written book and should be of much value to practitioners everywhere who are desirous of procuring at a glance the preferred methods of handling the many ailments of modern practice.

---

Atlas of Human Sex Anatomy: Robert L. Dickinson, M.D. Williams and Wilkins Company, Baltimore 1949 — price $10.00 Second Edition.

The book primarily intended to add to the current knowledge of sex education, is likewise written for those interested in marriage counselling, so that they may be better enabled to give advice concerning sex

(*Continued on page* 58)



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problems. These problems in the past have been neglected, and too often the entire subject has been taboo.

The text and commentary comprises the first section of the book and consists principally of anatomical considerations of the bony pelvis, male and female sex organs, and other anatomical considerations of the many sex problems.

The second section is the atlas proper with 175 figures which are divided among such categories as the bony pelvis, uterus, ovaries and tubes, — the vagina, — the vulva and breast, — male genital anatomy the anatomy of coitus and the anatomy of the control of conception.

In order that such a volume could be prepared, the author has not only used a very extensive bibliography, but has made many visits to museums in various parts of the world, for comparative studies and other essential data.

The many illustrations are excellent, covering a subject which is too often neglected, and which should be of much value to those interested in the subject from a scientific standpoint, or in the role of marriage counselling. It seems quite obvious to the reviewer, that the wealth of information contained in this volume should be studied carefully by physicians far and wide, so they would be better prepared to aid in the solution of many intimate problems of marriage, and particularly those contemplating matrimony.

The book should be a welcomed addition to the modern medical library.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

BREAST DEFORMITIES AND THEIR REPAIR: By Jacques W. Maliniac, M.D., Clinical Professor of Plastic Reparative Surgery and Associate Attending Plastic Reparative Surgeon, New York Polyclinic Medical School and Hospital, New York City, Attending Plastic Surgeon, Sydenham Hospital, Diplomate, American Board of Plastic Surgery Grune & Stratton, New York, 1950, 193 pages. $10.00.

AMPUTATION PROSTHETIC SERVICES: By Earle H. Daniel, Director of Prosthetic Service, Institute of Physical Medicine and Rehabilitation, New York University, Bellevue Medical Center, Prosthetic Consultant to Bellevue, City, Goldwater Memorial, Metropolitan and University Hospitals, New York,

(*Continued on page* 60)



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---

*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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## BOOKS RECEIVED (Continued)

New York. Foreword by Howard A. Rusk, M.D. The Williams & Wilkins Company, Baltimore, 1950. 327 pages. $7.00.

DELAYED UNION IN FRACTURES OF THE LONG BONES: By Kenneth W. Starr, O.B.E., E.D., M.D., B.S. (SYD) M.S. (MELB), F.R.C.S. (Eng.) F.A.C.S., F.R.A.C.S. Butterworth & Co. (Publishers), Ltd., London, England. The C. V. Mosby Company, St. Louis, Mo., U.S.A., 1947. 215 pages. $9.00.

PENICILLIN AND STREPTOMYCIN IN THE TREATMENT OF INFECTION: By Chester S. Keefer, M.S., M.D., ScD. (HON.) and Donald G. Anderson, M.D. Oxford University Press, New York, 1950. $2.50.

SEX WITHOUT FEAR: By S. A. Lewin, M.D. and John Gilmore, Ph.D., Foreword by Sarah K. Greenberg, M.D., Lear Publishers, Medical Division, New York, 1950. 121 pages. $3.00.

LOVE IS NOT ENOUGH: The Treatment of Emotionally Disturbed Children. By Bruno Bettelheim. The Free Press, Glencoe, Illinois. 386 pages, 1950. $4.50.

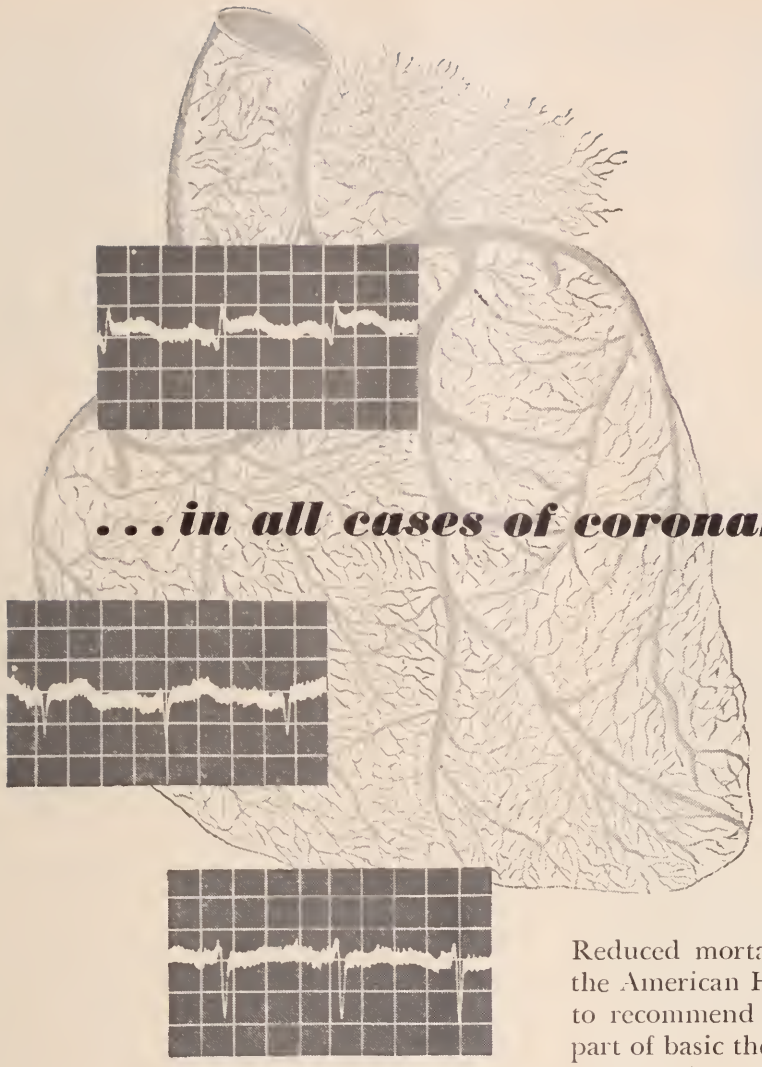
SIMMONDS' DISEASE, Extreme Insufficiency of the Adenohypophysis. By R. F. Farquharson, M.B., F.R.C.P. (C) Professor of Medicine and Head of the Department, University of Toronto, Physician-in-Chief, Toronto General Hospital, Toronto, Canada. Charles C. Thomas Publisher, Springfield, Illinois. 93 pages. $2.00.

AMUSING QUOTATION FOR DOCTORS AND PATIENTS: Edited by Noah D. Fabricant, M.D. Grune & Stratton, Inc., New York, 1950. 149 pages. $3.00.

A TEXT-BOOK OF PYSCHIATRY FOR STUDENTS AND PRACTITIONERS: By Sir David Henderson, M.D., (Edin.) F.R.F.P.S. (Glas.), F.R.C.P. (Ed. and Lon.) Physician-Superintendent of the Royal Edinburgh Hospital for Mental Disorders, and Professor of Psychiatry, University of Edinburgh. Oxford University Press, New York, New York, 740 pages. $7.75.

THE PRACTICE OF MEDICINE: By Jonathan Campbell Meakins, C.B.E., M.D., LL.D., D. Sc. Fifth Edition. With 518 illustrations including 50 in color. The C. B. Mosby Company, St. Louis, 1950. 1558 pages. $13.50.



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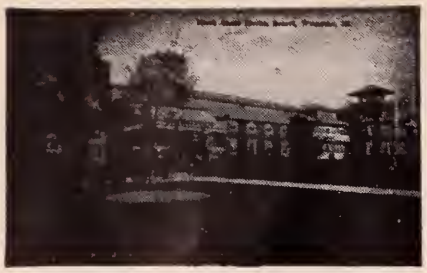
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*1. Wright, et al: Am. Heart J. 36, 801 (Dec.) 1948.*

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This is the conclusion of a group of U. S. Army Medical Corps officers who made a controlled study of the drugs (tripelennamine hydrochloride and chlorothen citrate) at West Point.

An effort was made to ascertain whether patients receiving medicaments early in the course of their illness were more likely to be cured than those starting treatment later.

"Patients who began treatment within 24 hours after the onset of a head cold were about as likely to be among those reporting no help as among the group reporting cures," the researchers say in the May 13 Journal of the American Medical Association. They added:

"This was approximately equally true of patients receiving all forms of treatment (including placebos)."

The antihistaminic drugs appear to lessen


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nasal discharge, however, the article indicates.

There has been a paucity of control studies of the effects of antihistaminic drugs on the common cold, the authors point out. Any form of treatment of the common cold is influenced by so many factors that only a controlled study provides results on which valid conclusions can be based.

The West Point study included 190 patients, all healthy young men in the military service. Medical attention was given before duties were begun, eliminating the temptation to report to sick call to avoid duties. Physicians prescribing treatment and making the follow-up examinations 72 hours after treatment was begun were unaware of what medicines the patients were receiving.

The study was made by Lieut. Col. R. J. Hoagland, Capt. E. N. Deitz, Lieut. P. W. Myers and Lieut. H. C. Cosand.

---

Statesmen and economists all over the world seem to realize the close relation between health and economy, health and social conditions, health and the standard of living. WHO Newsletter, July-August, 1949.


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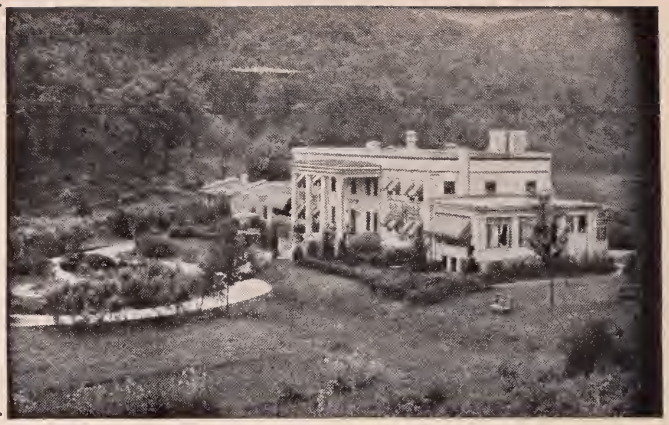
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## U. S. RANKS WITH LEADING NATIONS IN PREVENTING INFANT DEATHS

Rapid strides in improving and applying medical techniques of caring for babies have made the United States practically equal to any other nation in the world in preventing infant deaths, an American Medical Association study shows.

The study, which was recently completed by Frank G. Dickinson, Ph.D., and Everett L. Welker, Ph.D., Chicago, of the A.M.A. Bureau of Medical Economic Research, and published as Bulletin 73, is summarized in the April 1st Journal of the association.

One reason for the marked improvement in this country's infant death rate is that in recent years the two diseases which are the major causes of deaths of babies over one month and under one year — pneumonia and infant diarrhea — have largely been conquered in most sections of the United States, according to Dr. Dickinson.

This medical advance has brought about a reduction in deaths of babies from six months to a year of age, he said. During 1946, the latest year for which specific information is available, the United States had the world's lowest infant death rate for this age group.

The difference between the infant death rates of

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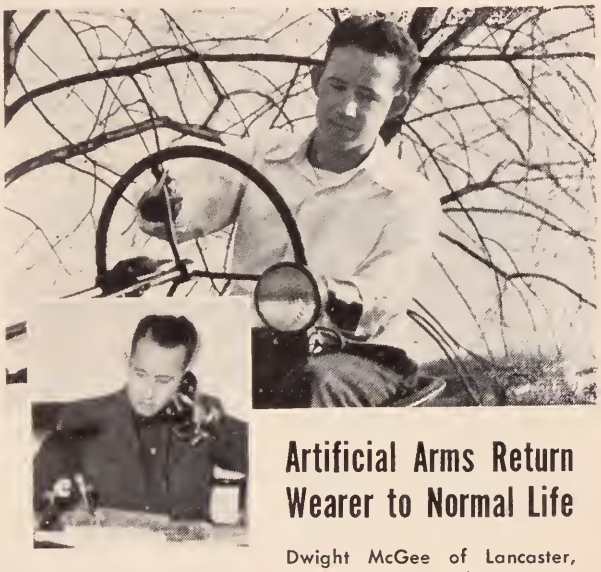

this country and New Zealand, the leader, for the first month of life is largely a statistical illusion, the study shows. Differences between the definitions and rules of the two countries regarding stillbirths and early infant deaths explain two thirds of the difference between the current total infant death rates of the two countries.

Also, the United States includes in its computation of infant death rates, the infant deaths among all racial groups, a fact which helped to give Arizona, New Mexico and Texas, where numbers of American Indians and persons of Spanish-American (Mexican) descent are found, the highest total infant death rates for 1948 in the nation, New Zealand excludes infant deaths among its native Maoris.

The decline in infant deaths in the United States during the last 15 years has been very great. Since the middle 1930's, the infant death rate for the United States declined from 56 in 1935 to 32 in 1947, while the rate for New Zealand declined from 32 to 25, Dr. Dickinson said.

---

The study of tuberculosis cannot be separated fruitfully from that of other pulmonary diseases. The teaching of the disease should be organized in conjunction with that in other pulmonary diseases from the standpoint of physical findings, clinical course, differential diagnosis, and management. Robert G. Bloch, M.D., Bull. Nat. Tuberc. A., January, 1950.

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# Medical Journal

VOL. 98 NO. 2

August, 1950


## Transurethral Resection of the Prostate Gland

## Local Antihistaminic Agents in Ophthalmology

## Management of Abortions

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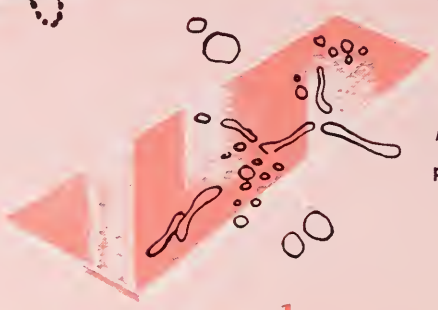
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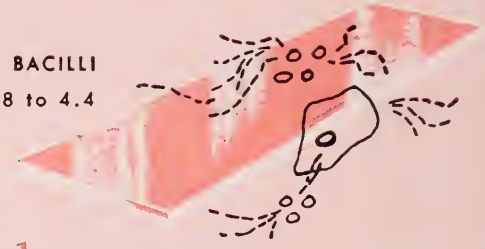
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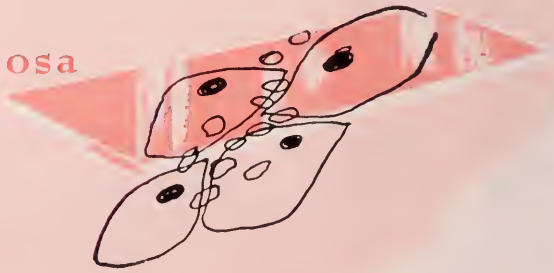
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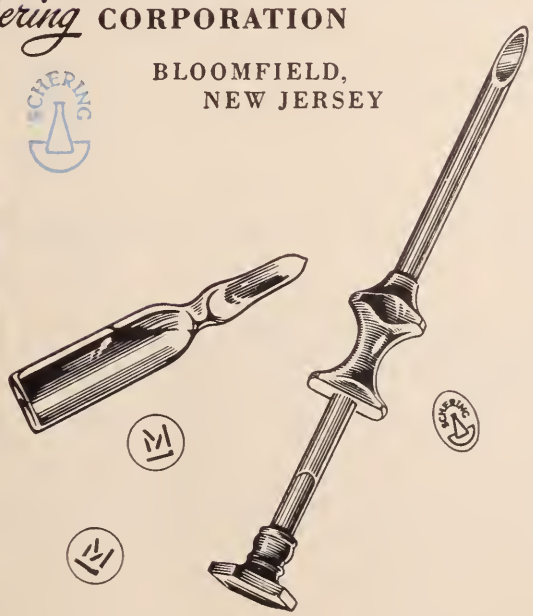
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*Dexter, H.: Studies in Acne, J.A.M.A. 142:715 (March 11) 1950

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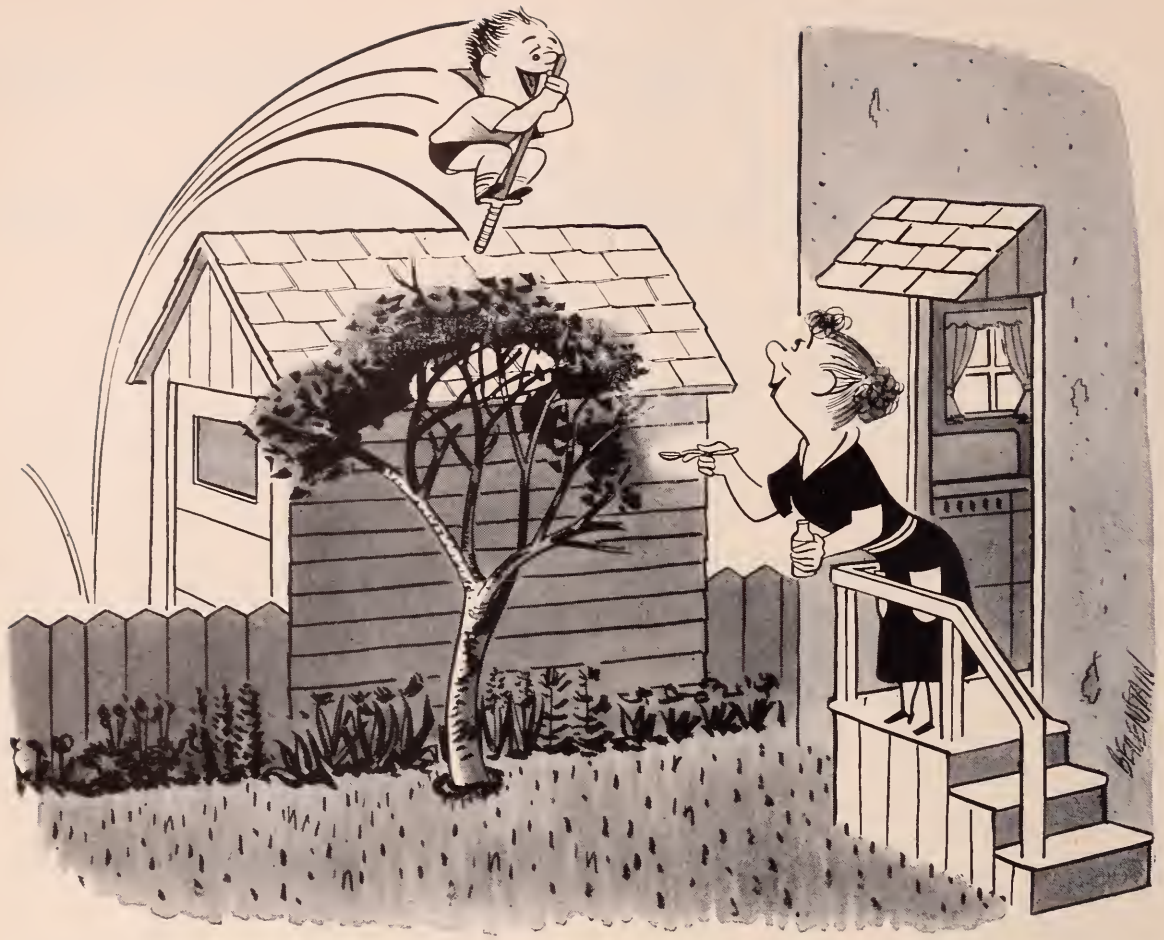
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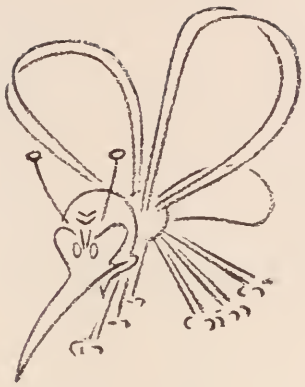
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*Wilbur, D. L.: Principles in the Use of Vitamins in Treatment: I. Vitamin Deficiency Diseases. Gastroenterology, 1:179, Feb., 1943.

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* Hamblen, E. C.: Some Aspects of Sex Endocrinology in General Practice, North Carolina M. J. 7:533 (Oct.) 1946.

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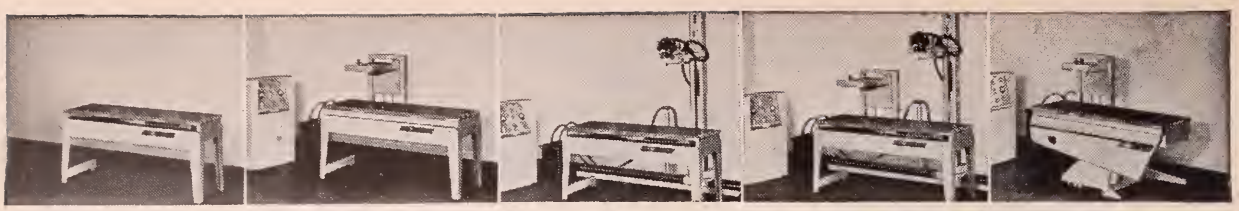
I.V.C.®

**OL-VITUM® CAPSULES** are also available

International Vitamin Division **IVES-CAMERON COMPANY, INC.,** New York 16, N. Y.

1. Kasdon, S. C., and Cornell, E. L.: Am. J. Obstet. & Gynec. 56:853 (Nov.) 1948.

*Equivalent (by biological assay) to 1.5 mg. d, Alpha Tocopherol



*A complete range of x-ray apparatus in 10 easy steps!*



# THE GE MAXICON meets the medical profession's long-felt need for x-ray equipment developed to grow with an expanding practice . . . providing just the x-ray facility required . . . unit by unit as needed!

MORE than just a new x-ray unit, the Maxicon is a fundamentally new idea for a comprehensive line of x-ray apparatus. Specifically designed to grow with your practice Yes, the Maxicon permits you to choose only the x-ray facilities you actually want or require — from the simplest to the most complete unit. Comprised of a number of components that can be assembled in various combinations, it covers the range of diagnostic x-ray apparatus from the horizontal x-ray table to the 200-milliampere, two-tube, motor-driven combination unit.

The Maxicon series has a wealth of utility wherever diagnostic x-ray is employed. The practicing physician may select the basic unit, then let x-ray grow with his practice — by simply adding successive components from time to time. The medical specialist may arrange to have only the x-ray facilities his specialty requires.

The clinic or hospital will appreciate the application of a simple unit as auxiliary equipment in a busy department, or a complete radiographic and fluoroscopic combination to adequately meet the demands of any type of examination. Ask your GE representative for unique booklet demonstration.



**GENERAL ELECTRIC X-RAY CORPORATION**

Chicago . 1417 West Jackson Boulevard
St. Louis . . 3724 Washington Boulevard
Des Moines . . . 405 Sixth Avenue
Springfield . . . . 212 West Laurel



**drowsiness** *minimized . . .*

*allergic patients remain alert . . .*

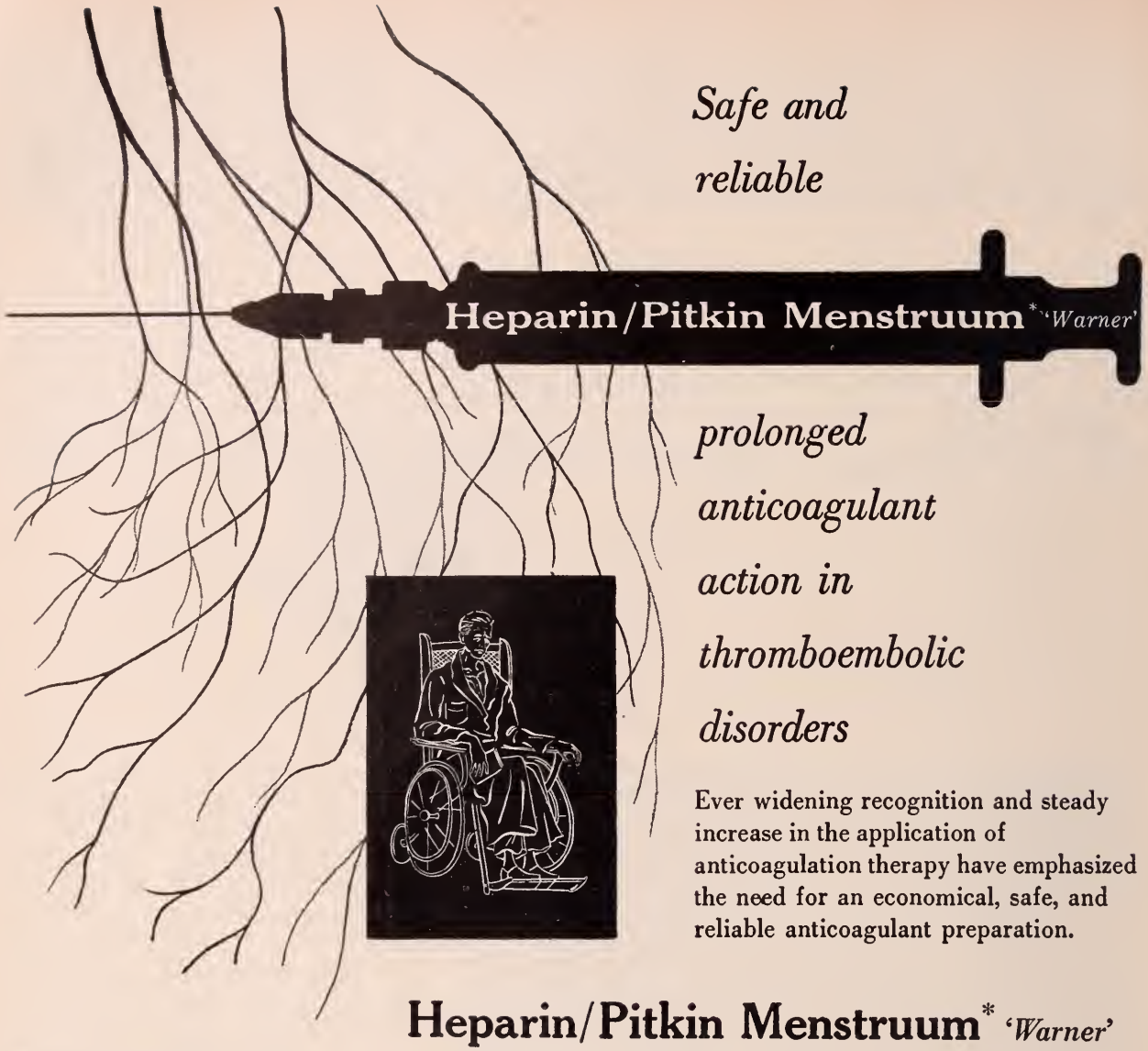
Clinical reports describing the use of Thephorin in 2564 patients with hay fever and other allergies indicate an incidence of drowsiness of only 2.92%. In contrast with other antihistamines, Thephorin can therefore be given to motorists and other patients who have to remain alert. Highly effective and well tolerated in most cases, Thephorin is available in 25-mg tablets and as a palatable syrup which permits convenient adjustment of dosage.

HOFFMANN-LA ROCHE INC • NUTLEY 10 • N. J.

**Thephorin**®

*brand of phenindamine*

**'Roche'**




*Safe and reliable*

*prolonged anticoagulant action in thromboembolic disorders*

Ever widening recognition and steady increase in the application of anticoagulation therapy have emphasized the need for an economical, safe, and reliable anticoagulant preparation.

# Heparin/Pitkin Menstruum* *'Warner'*

**PACKAGE INFORMATION:**

*Heparin/Pitkin Menstruum* 'Warner' (plain)*
without Vasoconstrictors
Cartons, 1 and 6 ampuls each
2-cc ampuls, each containing 200 mg heparin sodium salt
3-cc ampuls, each containing 300 mg heparin sodium salt

*Heparin/Pitkin Menstruum* 'Warner'*
with Vasoconstrictors
Cartons, 1 and 6 ampuls each
2-cc ampuls, each containing 200 mg heparin sodium salt with vasoconstrictors**
3-cc ampuls, each containing 300 mg heparin sodium salt with vasoconstrictors***
**Each cc of the Menstruum contains 12.5 mg of ephedrine sulfate and 0.5 mg. of epinephrine hydrochloride
***Each cc of the Menstruum contains 8.3 mg of ephedrine sulfate and 0.33 mg of epinephrine hydrochloride

*References:* (1) Loewe, L., Hirsch, E., Grayzel, D.M., and Kashdan, F.: Experimental Study of the Comparative Action of Heparin and Dicumarol on the *In Vivo* Clot, *J. Lab. Clin. Med.*, 33:721, 1948.
(2) Evans, J. A., and Dee, J. F.: Anticoagulant Treatment of Postoperative Venous Thrombosis and Pulmonary Embolism, *New Eng. J. M.*, *238*:1, 1948.

provides the means for prolonged anticoagulation action which affords "... consistently satisfactory results."(1) HEPARIN/PITKIN MENSTRUUM* 'Warner' inaugurated a new era in the preventive and therapeutic use of heparin in thromboembolic disorders, venous and arterial.

Evans and Dee(2) comment that "... the advent of heparin in Pitkin menstruum will popularize anticoagulant therapy as a safe and reliable method of treatment."

**William R. Warner & Co., Inc.**
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in hypertension
the blood pressure
drops

# VERILOID*

*Product of Riker Research*

*A potent alkaloidal fraction of Veratrum viride—biologically standardized for hypotensive activity in mammals—a new active principle not heretofore available, for the treatment of hypertension.*

BIOLOGICALLY STANDARDIZED IN MAMMALS. Veriloid is carefully standardized in dogs; drop in blood pressure is used as the end point. In consequence, its hypotensive activity does not vary from tablet to tablet, from bottle to bottle, or from batch to batch. It is the first preparation of its kind available for clinical use.

PROMPT CLINICAL RESPONSE. The effect of Veriloid on the blood pressure is apparent within an hour or two after administration. While individualization of dosage is essential for maximum benefit, in the majority of patients the average dose of 2.0 mg. to 5.0 mg. three or four times daily after meals and at bedtime leads to a significant, sustained drop in arterial tension with concomitant subjective improvement.

PROLONGED THERAPY POSSIBLE. In most patients, treatment with Veriloid may be continued as long as necessary. Unlike many other hypotensive agents, Veriloid usually may be given without decrease in therapeutic effect, since drug tolerance is not likely to develop. Frequently, reduction in dosage is possible as the circulatory system improves from the lowered arterial tension.

*Veriloid is available on prescription through all pharmacies in slow dissolving tablets containing 1.0 mg., in bottles of 100 and 200.*

*Trade Mark Riker Laboratories, Inc.

**RIKER LABORATORIES, INC., 8480 BEVERLY BLVD., LOS ANGELES**



# prompt symptomatic relief in hay fever

Your hay-fever patient wants most of all the ability to breathe normally —so that he can eat and enjoy it, sleep and be rested, work and play unhandicapped. For him, you can recommend Benzedrex Inhaler and be virtually sure that it will free him promptly of hay fever's most annoying symptoms.

**Benzedrex Inhaler**
has four outstanding advantages:

1. More rapid vasoconstriction
2. More prolonged vasoconstriction
3. Clean, medicinal odor
4. No excitation or wakefulness

*Smith, Kline & French Laboratories, Philadelphia*

# Benzedrex Inhaler

***the best inhaler ever developed***

*'Benzedrex' T.M. Reg. U.S. Pat. Off.*

# AUREOMYCIN

## CRYSTALLINE

*in Infections of the Puerperium*

During the past year, obstetricians have become increasingly impressed with the ability of aureomycin to prevent or arrest infections of the puerperium. Where infection is feared, or has appeared, this broadly effective antibiotic is highly useful. Drug fastness and allergy are very rare following aureomycin. It is believed that this new crystalline form of aureomycin obviates nearly all side reactions.

Aureomycin



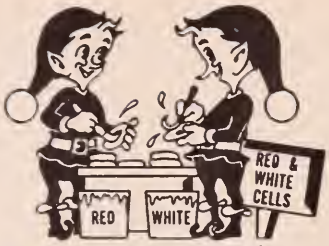
**Capsules:**
Bottles of 25, 50 mg. each capsule.
Bottles of 16, 250 mg. each capsule.

**Ophthalmic:**
Vials of 25 mg. with dropper;
solution prepared by adding
5 cc. of distilled water.

Aureomycin has also been found effective for the control of the following infections:

Acute amebiasis, bacterial infections associated with virus influenza, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, brucellosis, chancroid, Friedländer infections (Klebsiella pneumonia), gonorrhea (resistant), Gram-negative infections (including those caused by some of the coli-aerogenes group), Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, peritonitis, pertussis infections (acute and subacute), primary atypical pneumonia, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, sinusitis, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia, typhus and the common infections of the uterus and adnexa.

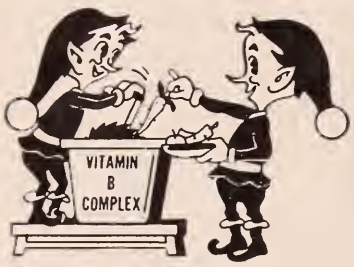
LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 20, N. Y.




**QUESTION:** *How many red blood cells are replaced due to "wear and tear"?*

**ANSWER:** *Approximately 25 million a day in normal people*




When abnormal demands overtax the blood forming capacity of the body producing easy fatigability, sub-clinical anemia too often does not receive corrective treatment until more serious symptoms urgently demand attention.

Frequently more than just iron deficiency is involved. The patient does not respond to simple iron therapy and other factors must be added.




Livitamin, "the first thought in hypochromic anemias," combines liver with iron and B complex vitamins, including vitamin $B_{12}$. Available as a palatable liquid or easily swallowed capsules, Livitamin provides a complete approach to the successful treatment of the hypochromic anemia syndrome.




Available on prescription in all pharmacies.

Write for sample and literature.

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Bristol, Tenn.-Va.

NEW YORK • SAN FRANCISCO • KANSAS CITY

*Livitamin*

LIQUID AND CAPSULES



Stops wracking cough...



but keeps the cough reflex

MERCODOL provides prompt, selective relief that doesn't interfere with the cough reflex needed to keep throat passages and bronchioles clear.

This complete, pleasant-tasting prescription contains a *selective* cough-controlling narcotic[1] that doesn't impair the beneficial cough reflex . . . an effective bronchodilator[2] to relax plugged bronchioles . . . an expectorant[3] to liquefy secretions. Remarkably free from nausea, constipation, retention of sputum, and cardiovascular or nervous stimulation.

# MERCODOL®

**THE ANTITUSSIVE SYRUP THAT CONTROLS COUGH—*KEEPS* THE COUGH REFLEX**

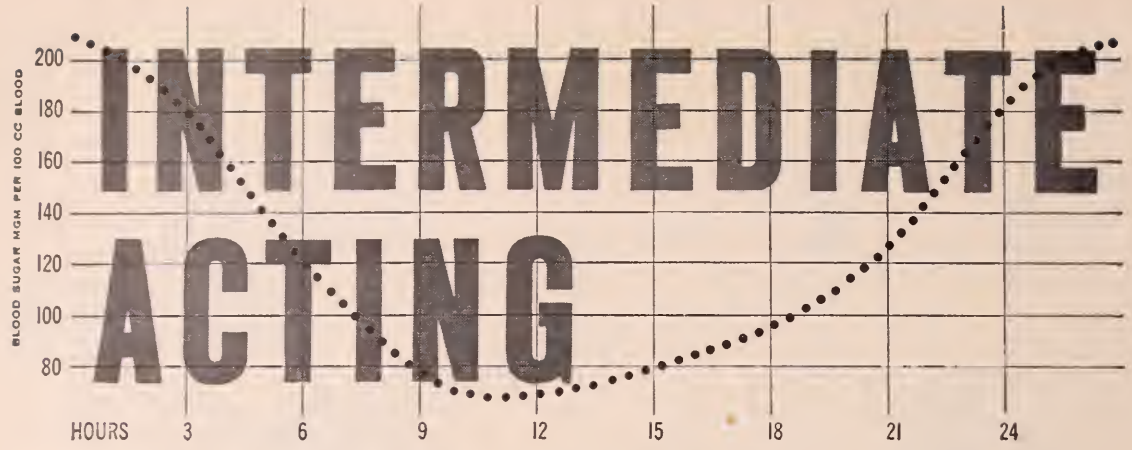
**An exempt narcotic**

**MERCODOL with DECAPRYN®**
**for the cough with a specific allergic basis.**

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1828
CINCINNATI • U.S.A.

Each 30 cc. contains:

| | | |
|---|---|---|
| [1] | Mercodinone® | 10.0 mg. |
| [2] | Nethamine® Hydrochloride | 0.1 Gm. |
| [3] | Sodium Citrate | 1.2 Gm. |




# INTERMEDIATE ACTING

# GLOBIN INSULIN

## 'B.W.& CO.'

*...was developed to fill the "need for an insulin with activity intermediate between that of regular insulin and that of protamine zinc insulin."*[1]

**IN 1939,** Reiner, Searle and Lang described a new "intermediate acting" insulin.

**IN 1943,** after successful clinical testing, the new substance was released to the profession as 'Wellcome' brand Globin Insulin with Zinc 'B. W. & Co.'

**TODAY,** according to Rohr and Colwell, "Fully 80% of all severe diabetics can be balanced satisfactorily"[2] with Globin Insulin 'B.W. & Co.'—or with a 2:1 mixture of regular insulin: protamine zinc insulin. *Ready-to-use* Globin Insulin 'B.W. & Co.' provides the desired intermediate action without preliminary mixing in vial or syringe.

*In 10 cc. vials, U-40 and U-80.*




**'B.W.& CO.'—a mark to remember**

1. Rohr, J.H., and Colwell, A.R.: Arch. Int. Med. 82:54, 1948.
2. ibid Proc. Am. Diabetes Assn. 8:37, 1948.

**BURROUGHS WELLCOME & CO. (U.S.A.) INC.** Tuckahoe 7, New York

*Triple treatment for*



## *DIARRHEA*

(specific and nonspecific)

# Cremosuxidine®

Suspension of

1 *Sulfasuxidine®* succinylsulfathiazole, 10.0%

2 *Pectin*, 1.0%

3 *Kaolin*, 10.0%

SHARP & DOHME

Diarrhea is a nuisance, "one of the commonest symptoms of illness in the human race,"* and a real menace, accounting for nearly 1% of deaths reported in the United States. In ten Southern states, in 1946, more deaths were reported due to diarrhea than to typhoid and scarlet fevers, pertussis, diphtheria, malaria, measles, and poliomyelitis combined!* *Cremosuxidine®* offers a new, palatably flavored, exceptionally effective triad for control of specific and nonspecific diarrheas: potently bacteriostatic, relatively nontoxic *Sulfasuxidine®*, detoxicant *pectin*, and protective, adsorbent *kaolin*. *Cremosuxidine* may be administered for bacillary dysentery, paradysentery, salmonellosis, diarrhea of the newborn, and so-called "summer complaint." Supplied in *Spasaver®* bottles containing 16 fluidounces. Sharp & Dohme, Philadelphia 1, Pa.



*Gray, A. L.: Southern Med. J., 43:320, April, 1950.



**Patient**

**under Treatment**

FOR URINARY

TRACT INFECTION

**meantime enjoys**

***Gratifying Relief***

**from distressing symptoms**

With orally administered Pyridium—an effective, *safe* urinary analgesic—physicians can give patients with urinary tract infection prompt relief from such symptoms as urinary frequency and pain and burning on urination.

Pyridium in therapeutic dosage is virtually nontoxic and may be administered throughout the course of treatment with streptomycin, penicillin, the sulfonamides, or other specific therapy.

*Pyridium is the trade-mark of Nepera Chemical Co., Inc., successor to Pyridium Corporation, for its brand of phenylazo-diamino-pyridine HCl. Merck & Co., Inc. sole distributor in the United States.*

*The complete story of Pyridium and its clinical uses is available upon request.*




# Pyridium®

(Brand of Phenylazo-diamino-pyridine HCl)

MERCK & CO., INC. *Manufacturing Chemists* RAHWAY, NEW JERSEY

*In Canada:* Merck & Co. Limited—Montreal, Que.




Rapid, sustained relief follows topical application of CALADRYL—the soothing new calamine-type antipruritic lotion containing BENADRYL®

# CALADRYL

TRADE MARK

**effective:** CALADRYL effectively relieves sunburn and itching. Benadryl hydrochloride (1%), calamine, camphor, glycerin and other ingredients are blended in a soothing lotion for effective antihistaminic and antipruritic action.

**pleasant:** CALADRYL is pleasant to use. Faintly perfumed, its light flesh color is cosmetically inconspicuous. It does not rub off but washes off easily.

**versatile:** CALADRYL has many uses. It soothes sunburn's itching and burning. Prickly heat, diaper and cosmetic rash are readily relieved as is the itch associated with hives, insect bites, poison oak, poison ivy, measles, chicken pox, contact dermatitis, and minor skin affections.

**PARKE, DAVIS & COMPANY**

MEDICAMENTA VERA



*to ameliorate mood...* *to relieve inner tension*

'DEXAMYL'—a balanced combination of 'Dexedrine'* and 'Amytal'†
—provides the beneficial effects of both its two components:

The 'Dexedrine', because of its "smooth" and profound antidepressant **action,** restores mental alertness and optimism and dispels psychogenic fatigue.

The 'Amytal', because of its calming action, relieves nervous tension, anxiety and agitation.

Combined in DEXAMYL, the two components work together synergistically to control troublesome symptoms of mental and emotional distress.

Widely useful in everyday practice, 'Dexamyl' tablets are available in bottles of 50. Each tablet contains 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.) 5 mg. and 'Amytal' (Amobarbital, Lilly) ½ grain (32 mg.).

*Smith, Kline & French Laboratories, Philadelphia*

# Dexamyl*

*Trademark, S.K.F.
†Trademark, Lilly






# NOW PROOF . . . in an instant, Doctor, PHILIP MORRIS are LESS IRRITATING

*Just Make This Simple Test:*





**1** . . . light up a PHILIP MORRIS

Take a puff—DON'T INHALE. Just s-l-o-w-l-y let the smoke come through your nose. Easy, isn't it? AND NOW . . .

**2** . . . light up your present brand

DON'T INHALE. Just take a puff and s-l-o-w-l-y let the smoke come through your nose. Notice that bite, that sting? Quite a difference from PHILIP MORRIS!

YES, your own *personal experience* confirms the results of the clinical and laboratory tests.* With proof so conclusive, would it not be good practice to suggest PHILIP MORRIS to your patients who smoke?

## PHILIP MORRIS

Philip Morris & Co., Ltd., Inc.
100 Park Avenue, New York 17, N. Y.

**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*



# 3,000,000

## HAY FEVER SUFFERERS COME TO YOU FOR RELIEF

*Doctor*

*prescribe*

# CEHISTRA

'ORGANON'

Nearly 3,000,000 hay fever sufferers—seven out of every ten who have this distressing malady—come to you and other physicians for relief. You can offer many of your patients prompt, gratifying relief by prescribing Cehistra, for it provides an effective dual attack on hay fever symptoms. Cehistra combines in each effervescent tablet 10 mg. of prophenpyridamine (available as the maleate), one of the most effective antihistaminics available today, and 100 mg. of vitamin C, in itself valuable in helping the defense mechanism, together with 320 mg. (5 grs.) of aspirin and several alkalizers. Cehistra tablets form in water a sparkling, pleasant-tasting, effervescent solution which assures prompt action in the symptomatic relief of most common allergies because the active ingredients are available in complete solution ready for immediate use by the body. You and your patients will be pleased with the therapeutic efficacy, remarkable freedom from untoward effects, and superior palatability of Cehistra.

*Dosage:* One tablet, dissolved in a glass of water, every 3 or 4 hours.

*Availability:* Vials of 10 effervescent tablets. Cehistra is never advertised to the laity.

ORGANON INC. • ORANGE, N. J.




## fully effective

Control of appropriate anemias
with liver extract
is a long-recognized
and well-established certainty.

The integration of several potent facto
not just one,
makes liver extract therapy complete.

For uniformity of effect,
Lilly Liver Extracts
are repeatedly standardized
on suitable patients in relapse.
Thus, satisfactory clinical response
is both an unvarying requirement
of the manufacturer
and your assurance of
constant effectiveness.

*Lil*




Detailed information and literature on LILLY LIVER EXTRACTS are supplied through your M.S.R.*

*M.S.R.—Lilly Medical SERVICE Representative



*A 19" x 12" reproduction of this illustration by Stevan Dohanos is available upon request.*

## the blue ribbon

All country roads lead to the State Fair, where well-deserved recognition is given the diligent care which develops better livestock. A growing abundance of healthy animals assures an increasing source of glands for pharmaceutical processing. This constant improvement of supply is matched by ever-progressing methods of production in the Lilly Laboratories. The public benefits through better products at lower cost.

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INDIANA, U.S.A.

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR. Theodore R. Van Dellen, ASSOCIATE EDITOR.

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Vol. 98, No. 2 August, 1950

## SAN FRANCISCO MEETING OF THE A.M.A.

The San Francisco meeting of the American Medical Association was one of the outstanding meetings of this great organization from the standpoint of attendance, interest and accomplishments. By the end of the second day the registration was nearly 10,000 physicians, and the total registration approximately 20,000. The scientific programs were well arranged, and more than 300 papers were presented. There were 157 scientific exhibits covering all phases of modern medical practice.

The technical exhibits likewise were unusual both in number and in the materials presented. The total number of technical exhibits was 304. Numerous television programs were presented, some of which were telecast over Eastern networks. There were likewise many radio broadcasts from the meeting. For the first time the induction of the President-Elect to the office of President on Tuesday evening was presented over a national radio hook-up, and for the first time also the new president received an oath of office.

The House of Delegates was in session most of the time from Monday through Thursday, and with a total of 196 delegates comprising the House, 193 delegates were certified. The many resolutions, reports and recommendations were, as usual, referrred to reference committees for hearings, then the reports back to the House, and action was taken on each of them in an orderly manner. At some of the committee hearings many members of the A.M.A. appeared to give their views of the subjects under discussion, and the proceedings were conducted in a true democratic manner as usual.

One of the first duties at the annual session each year is the selection by the House of Delegates of the physician to receive the Distinguished Service Medical. Three candidates were presented for the award, and the winner was Evarts A. Graham, M.D., head of the Department of Surgery at Washington University School of Medicine, St. Louis. Doctor Graham, for many years an outstanding surgeon, has been professor of surgery at Washington University since 1919. Born in Chicago, and the son of a prominent Illinois surgeon who for a number of years was Secretary of the Illinois State Medical Society, Doctor Graham received his medical degree from Rush Medical College in 1907. With Warren H. Cole, in 1924, Doctor Graham introduced cholecystography, the method which has since been known as the Graham-Cole test. In 1933 he reported the first successful removal of an entire lung in one stage for carcinoma of the bronchus. The medical profession of America is proud of the many accomplishments of this

truly master surgeon, and Illinois is proud of him as a native son who received his medical education in this state, and for a number of years was associated with his own father, Dr. D. W. Graham, who for many years was a professor of surgery at Rush Medical College.

At the Thursday afternoon session, John W. Cline of San Fransico was elected to the office of President-Elect, R. B. Robins, Camden, Arkansas, Vice-President, George F. Lull re-elected Secretary, and Josiah J. Moore, Chicago, re-elected as Treasurer. F. F. Borzell, Philadelphia and James R. Reuling, Bayside, New York were re-elected as Speaker and Vice-Speaker of the House of Delegates. Leonard Larson of Bismarck, North Dakota and Thomas P. Murdock of Meriden, Connecticut were elected as new members of the Board of Trustees.

The meeting places for the American Medical Association are selected three years ahead by the House of Delegates. The 1951 annual meeting is to be held in Atlantic City, Chicago in 1952 and New York City was selected as the meeting place for 1953. The 1950 Interim Session had been scheduled for Denver, but owing to some troubles in that city the Board of Trustees changed the meeting place to Cleveland, and the date will be December, 5-8.

As usual, the registration of physicians from Illinois was quite high, with several hundred members of the Illinois State Medical Society in attendance.

The membership dues for the next year were set by the House of Delegates at $25.00, and for the first time the annual dues will include subscription to the Journal of the American Medical Association.

With the largest number of resolutions ever presented before the House of Delegates at any session, the reference committees and individual members of the House were busy throughout the four days the House was in session. All, however, were well cared for and the complete transaction will be published in the Journal of the A.M.A., beginning July 15. We would urge all members of the American Medical Association to read carefully these transactions and see what your delegates are doing for your interests, as well as for the interests of the medical profession of the nation as a whole.

It is also recommended that every member read the Oath of Office taken by the President of the American Medical Association, which appeared in the July 8 issue of the J. A. M. A., as well as the address of the President which was published in the July 1 issue of the Journal, and which should be of much interest to all physicians.

Those who attended this fine 1950 Annual Meeting of the American Medical Association were thoroughly impressed with the work the Association has done and has planned for the future, in the effort to continue serving their many patients to the best advantage in the well established American way of practice.

A careful study of the many fine scientific exhibits well demonstrated the fact that American Medicine is constantly progressing, and bringing out new methods for improving health and combatting disease. May it continue on this free enterprise basis.

---

## MEMORY

What is Man's — meaning Humanity's, greatest asset? Think for a moment. Is it Sight? For eternal darkness is indeed a curse, a woeful, pitiful calamity! Stumbling and shuffling through a long lifetime, never glimpsing the sun, the moon, the stars, the glories of nature; the expressions of fellow human beings, the faces, the smiles, aye, even the tears of loved ones! Is *Sight* God's greatest gift to man? No, I rather think not!

Is it Hearing? The ability to sense the tone of music, of the operas, the gleeful chuckle of children and infants, the words of praise of friends, or even the denunciation of our enemies? No, not Hearing!

Is it Speech? That wondrous mechanism whereby we express our individualities and impose our will upon others? The power to declare our love and fidelity or the reverse, our dislikes, hates and fears? No, not even Speech!

What is man's most important, self-satisfying, God-given gift? Are you ready for the answer? Will you accept it? *"MEMORY."* Memory, that marvelous golden chain which links our yesterdays and todays with tomorrow! What good sight, hearing, speech, if fleetingly, they leave us dead-pan-flat! Memory alone allows us to live and relive any portion of our lives, — our Childhood, Youth, Maturity and Senility!

Of what value a trip around the world and a

view of all of its glories if we are never, never to be privileged to relive and re-enjoy it?

Yes, my friends, that mysterious, magical, intangible 'something' even removes the sting of our declining years! Thanks to "Memory" we can gracefully and fearlessly accept Senility, and in our dotage sit back and, quick as a flash, kaleidoscopically, unwind the reel of life and review at will our Childhood, Youth and Maturity. We relive our successes and failures, our triumphs and joys, and most important of all, we muse with satisfaction the many varied good and worthwhile entries we have spread upon our "Book of Life."

Dr. Robert Sixtus Berghoff
30 North Michigan Avenue
Chicago, Illinois.

## CORRECTION

In the article, "Observations on the Use of Aureomycin in the Treatment of Acute Anterior Poliomyelitis", by Erich Weis, M.D., and Burton J. Winston, M.D., Waukegan, Illinois, appearing on page 9 of our July issue, there is a transposition of lines in the first column on page 11.

In the paragraph headed *Comments,* the 14th line should appear two lines above its present position.

## MICHAEL REESE POST-GRADUATE SCHOOL

Michael Reese Hospital Postgraduate School offers a course in Diseases of the Endocrines, Physiology and Diagnostic Methods. The class will meet from September 18 through September 29, 1950 and will be under the direction of Dr. Rachmiel Levine, Director of the Department of Metabolic and Endocrine Research. The course will consist of a balanced program of lectures and case demonstrations. Tuition is $100.00. For further information and a detailed schedule, address: Dr. Samuel Soskin, Dean, Michael Reese Hospital Postgraduate School, 29th St. and Ellis Ave., Chicago 16, Ill.

## AMERICAN COLLEGE OF SURGEONS MEETS IN BOSTON IN OCTOBER

Color television of surgical procedures from Massachusetts General Hospital to an auditorium in Mechanics Hall is one of the features planned for the thirty-sixth Clinical Congress of the American College of Surgeons which will be held in Boston from October 23 to 27, according to an announcement by Dr. Paul R. Hawley, Director. Twenty-four hospitals in Boston and vicinity will hold operative clinics for the visiting surgeons during the week. Hotel headquarters will be at The Statler and Copley Plaza.

At the Presidential Meeting on Monday evening, October 23, Dr. Henry W. Cabe of New York will be installed as President and Dr. Warren H. Cole of Chicago as First Vice President.

# CORRESPONDENCE




## "A CENTURY OF HEALTH PROGRESS" AT QUINCY

The Adams County Medical Society, a component part of the Illinois State Medical Society and the oldest county medical society in Illinois, is doing the unusual by sponsoring a great public celebration October 13-17 to commemorate the centennial of its foundation. The Society was formally organized on March 28, 1850 and has held regular meetings except for one year during the Civil War. The celebration, which will be a non-profit affair, will be known as, "A Century of Health Progress" and will depict the progress of medical science during the past century. The principal things planned are a large technical and educational exhibit hall, a spectacular, colorful pageant under professional direction, a spirited street parade, an educational motion picture theater. Final plans have not been completed but call for the close co-operation of many of the civic organizations of Quincy in order to assure the success of the project.

The Society will be grateful for suggestions that will assure the success of the celebration. Dr. Harold Swanberg, W. C. U. Bldg., Quincy, Ill., is serving as General Chairman, Adams County Medical Society Centennial Celebration.

## PROGRESS MADE BY ILLINOIS MEDICAL SERVICE

The annual meeting of the participating physicians of Illinois Medical Service was held on June 20, 1950, the purpose of the meeting being to elect three trustees. The following trustees were elected to serve for a three-year term: Dr. Andrew C. Ivy; Dr. Willard O. Thompson; and Dr. C. Paul White, of Kewanee.

On June 21, 1950, the annual meeting of the Board of Trustees was held; and, also following that, the regular monthly meeting. At the annual meeting, the following officers were elected: President, Dr. Warren W. Furey; Vice-President, Dr. Harold W. Miller; Secretary, Dr. Percy E. Hopkins; Treasurer, Dr. Arkell M. Vaughn. Mr. E. P. Lichty was re-elected as executive director.

At the regular monthly meeting, Dr. Frederick W. Slobe was appointed medical director.

Illinois Medical Service now has an enrollment of over 225,000 members. Thirty-seven county medical societies have now endorsed the Plan and obtained signatures of over 51 per cent of the physicians in the respective counties as participants. These counties represent 90 per cent of the state's population. Enrollment in most of these counties is now proceeding but there is an understandable lag in enrollment preparatory

to the development of enrollment facilities in each area.

To date there have been over 17,000 claims paid, with an average cost of $17.44. Earned surplus as of May 31 was $333,558.83, indicating a sound financial position. Illinois Medical Service, as of May 31, 1950, has paid over $850,000 to physicians.

The officers and trustees solicit criticisms, suggestions and comments from physicians relative to the administration of the Plan.

Frederick W. Slobe, M.D.
Medical Director

## "YOUR MENTAL HOSPITALS" CURRENT REPORTS

There are four resident patients in the Illinois State Mental Hospitals for every one thousand persons in the State of Illinois. The average for the United States during 1948 was slightly more than three patients per 1,000 population. Data was recently released by the Public Health Service, National Institute of Mental Health, covering the State Mental Hospitals of the United States for the year 1948.

According to this report, Illinois was seventh on the list in the ratio of patients per 1,000 population. The State of New York was highest with 5.5 patients per 1,000. A high ratio of hospitalization does not mean that there are more patients in the state with mental illnesses. More patients are hospitalized in the more densely populated states. The differences in rate are fairly good indices of variation in the extent to which facilities for the care of the mentally ill are available.

The average daily resident population in the State Mental Hospitals throughout the country in 1948 was 463,000. There were 101,000 first admissions and 32,000 readmissions with a total of 76,000 discharges and 71,000 patients on extramural care. Comparing the figures for Illinois, for the same calendar year, there were 34,900 patients in the nine State Mental Hospitals. First admissions totaled 8,900 patients and readmissions totaled 4,000. Discharges during this period were 7,900 and there were 3,200 patients on extra-mural convalescent care.

The overcrowding of state hospitals in 1948, according to this same report, averaged 18.2 per cent for the entire country. The following is a list of states with overcrowding in excess of 40 per cent:—

| | EXCESS OF POPULATION | |
|---|---|---|
| Name of State | Number of patients | Percentage |
| Arizona | 541 | 63.6 |
| Illinois | 12239 | 55.8 |
| Louisiana | 2303 | 49.4 |
| Georgia | 2652 | 40.8 |

(In May 1950, the overcrowding in Illinois amounted to 13,605 patients or 62.5 per cent).

A comparison was made of the total number of employees per patient, the ratio of patients to the total staff. These figures include all categories of employees working at the institutions, not only the medical and nursing staffs, but the administrative, maintenance, clerical personnel, etc. This also includes personnel covering the three shifts that form the twenty-four hour day. The ratio of patients to total staff for the United States was 5.6. Thus, there were 5.6 patients for each employee in the mental hospitals of the United States. Illinois State Hospitals were twenty-second on the list with a ratio of 5.8 or slightly less than the United States average. (In May 1950, the ratio was 5.4).

The per capita expenditures during 1948 for the mental hospitals was $659.00 or approximately $1.80 a day. Illinois was sixth on the list with an expenditure of $788.00 per patient or $2.16 a day. The daily expenditures in general hospitals throughout the country averages considerably over $10.00 a day.

The National and Illinois data demonstrated in clear figures the overcrowding and understaffing of the State Mental Hospitals and deserves serious consideration.

G. A. Wiltrakis, M.D.
Deputy Director

## MEDICAL OFFICERS IN FEDERAL SERVICE

Medical Officer positions in the Federal Service paying $5400, $6400, and $7600 per year will be filled from an examination recently announced by the Director, Eighth U. S. Civil Service Region, Saint Paul, Minnesota. Positions paying the above cited salaries are now vacant and there is an immediate need to fill these positions. Medical doctors who have just completed their internship are eligible for the positions paying $5400. Medical doctors with one or two years experience performing respon-

sible medical doctor duties are eligible for the positions paying $6400 and $7600 per year respectively.

Applications for these positions will be accepted until further notice. Application forms may be obtained at any first- or second-class post office. A copy of the examination announcement may be obtained by writing the Director, Eighth U. S. Civil Service Region, Saint Paul Post Office and Customhouse Building, Saint Paul 1, Minnesota.

N. J. Oganovic
Regional Director

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR SEPTEMBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the September schedule of clinics for physically handicapped children. The Division will conduct 16 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in Cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September clinics are:

September 6—Rock Island (Cerebral Palsy), St. Anthony's Hospital
September 6—Joliet, Will Co. TB Sanitarium
September 7—Chester, St. John's Lutheran School
September 8—Chicago Heights (Rheumatic Fever), St. James Hospital
September 8—Rosiclare, Y.M.C.A.
September 12—Peoria, St. Francis Hospital
September 12—E. St. Louis, St. Mary's Hospital
September 13—Hinsdale, Hinsdale Sanitarium
September 14—Springfield, St. John's Hospital
September 14—Elmhurst (Rheumatic Fever, Memorial Hospital of DuPage County
September 19—Quincy, St. Mary's Hospital
September 19—Centralia, Franklin School
September 20—Springfield (Cerebral Palsy), Memorial Hospital
September 20—Sterling, Sterling Public Hospital
September 20—Alton, Alton Memorial
September 21—Rockford, St. Anthony's Hospital
September 22—Chicago Heights (Rheumatic Fever), St. James Hospital
September 22—Clinton, Y.M.C.A.
September 26—Peoria, St. Francis Hospital
September 26—Effingham (Rheumatic Fever), St. Anthony's Emergency Hospital
September 27—Evergreen Park, Little Company of Mary
September 28—Bloomington, St. Joseph's Hospital

A record number of 1091 physically handicapped children were examined in clinics conducted during May. The 17 general clinics provided diagnostic, pediatric, orthopedic, speech, and hearing examinations to 1021 children, an average of 60 per clinic. Four clinics for children with rheumatic fever had an average attendance of 13, with the one cerebral palsy clinic providing service for 17.

New clinic cases totaled 232. The previous high for any previous month was 995, which was in January of this year.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

# PICTURE STORY OF THE SPRINGFIELD MEETING

**For the first time in the history of the Illinois State Medical Society, the annual meeting was dedicated to one of its distinguished members, Andy Hall, of Mt. Vernon.**

**The 1950 annual meeting, held in Springfield, May 23-25, drew a total registration of 2,109. Exhibits, general assembly session, and motion pictures were in the Illinois National Guard Armory, which proved to be admirably adapted to the needs of the Society. The House of Delegates and special meetings were in the Hotel Abraham Lincoln.**



(above) Walter Stevenson, Quincy, retiring President of the Society, welcomes his successor, Harry M. Hedge, Chicago, to his new duties. Dr. Hedge, who has served the Society in many positions, is also a member of the Board of Health of Evanston, where he resides.



George E. Kirby of Spring Valley (left) had the pleasure of nominating and seeing his friend C. Paul White of Kewanee elected to the position of President-Elect.



Joseph S. Lundholm of Rockford is the new Councilor for the First District, replacing L. H. Hughes of Elgin, who had served for many years. Leo P. A. Sweeney has returned to the Council as a representative from the Third District. He replaced Walter C. Bornemeier of Chicago, who resigned because of other official duties.







More than 500 attended the Annual Dinner held at the Abraham Lincoln Hotel. (above) Andy Hall, Msgr. William J. Cassin, Harry M. Hedge, Walter Stevenson, and Percy E. Hopkins. Dr. Hopkins made an excellent toastmaster. (right) Oscar Hawkinson, then Chairman of the Council, Raymond Moley, principle speaker, Ernest E. Irons of the A.M.A., and Edwin S. Hamilton. Mr. Moley's speech was, "Freedom or Socialism — Which?"



(above) One of the tables at the Annual Dinner. Thomas J. Foley and Mrs. Foley, Louise Hatcher, all of Springfield, Margaret Hie Ding Lin, of Chicago, W. W. Fullerton and Mrs. Fullerton of Steeleville, Bernard Klein of Joliet, and Willis I. Lewis of Herrin.



(below) J. H. Edgcomb, J. T. O'Neill, Mrs. Harry M. Hedge, Mrs. O'Neill, Paul Ross, A. J. Magee and Mrs. Magee.



Among others in the group a
at the Annual Dinner are Fre
Muller and Esther Frazer
the Chicago Medical Society.



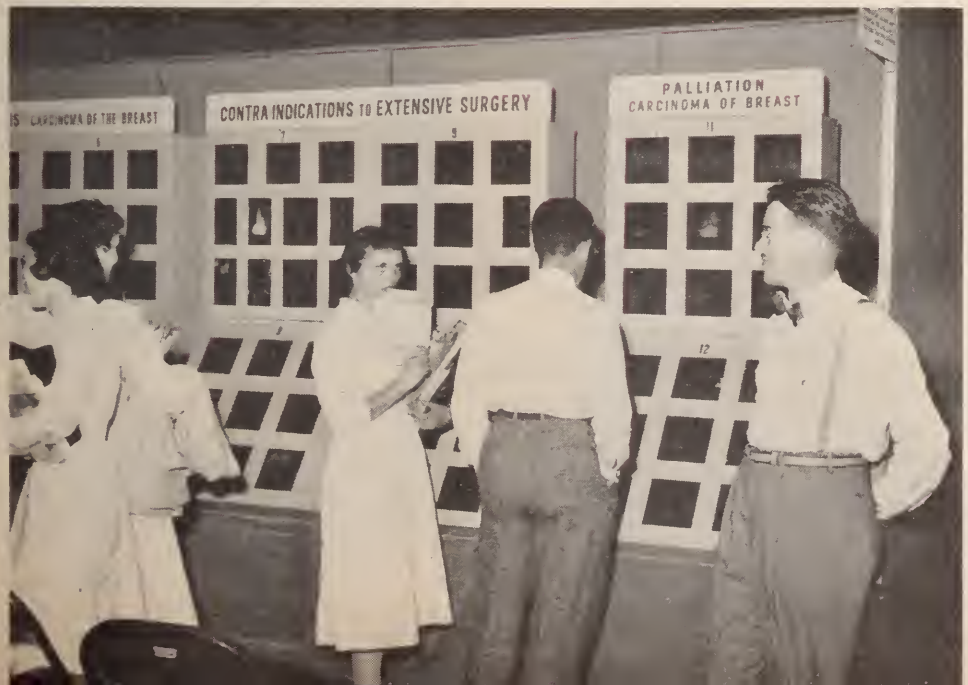
Andy Hall had a busy time at the meeting named in his honor. Shown above he is acting as Chairman at the annual luncheon of the Fifty-Year Club, which always proves to be one of the liveliest affairs at every meeting.



y of the speakers at the meeting were
out of state. Alfred T. Lieberman, As-
nt Professor of Otology and Laryngol-
Johns Hopkins University School of
icine, Baltimore, addressed the Section
ye, Ear, Nose and Throat. The title of
paper was, "The Problem of Deafness in
dren." He later addressed the general
mbly on, "Types and Treatment of Deaf-
."



Another out-of-state speaker was Wendell Johnson, Professor of Speech, State University of Iowa, of Iowa City. His subject was, "Stuttering and Stammering in Children."




Louis River and Joseph Silverstein were awarded the Gold Medal for Educational Value for their exhibit, "Carcinoma of the Breast: Diagnosis and Selection of Treatment."



Much credit must be given to the Sangamon County Medical Society for the success of the meeting. (left) Jacob E. Reisch of Springfield, General Chairman of the Committee on Arrangements is shown with his office assistant, Mrs. Mary McFarland.



The Women's Auxiliary had the best convention in its history. Mrs. Harry H. Southwick served as State Convention Chairman. At the right are shown Mrs. Carl E. Sibilsky of Peoria, the new President; Mrs. E. M. Egan, the retiring President; and Mrs. James McDonough, Chicago, the President-Elect.

(below) While members of the Women's Auxiliary were guests of the Sangamon County Auxiliary, the Local Committee under the direction of Richard F. Herndon, presented an old fashioned stag party at the Elk's Club, complete with a German band and hilariously funny skits. Three of the "actors" are H. B. Henkel, Sr., Murray E. Rolens, and E. G. Free.






An interested group attended the panel di cussion, conducted as an open forum. Pa ticipants who discussed problems of pub health were W. W. Bauer, J. J. Moore, E ward S. Hamilton, Harlan English, and Ta Kirkwood. Henrietta Herbolsheimer serv as moderator.

# STATE DEPARTMENT OF PUBLIC HEALTH



## Control of Poliomyelitis

The following recommendations are presented as control measures in poliomyelitis.

GENERAL PRECAUTIONS DURING OUTBREAKS:

1. The Illinois Department of Public Health will inform physicians and the general public as to the prevalence or increase in incidence of the disease.

2. EARLY DIAGNOSIS is extremely important. Common early signs of polio are: headache, nausea, vomiting, muscle soreness or stiffness, stiff neck, fever, nasal voice and difficulty in swallowing with regurgitation of liquids through the nose. Some of these symptoms may be present in several other diseases but in the polio season they must be regarded with suspicion.

3. ALL CHILDREN WITH ANY OF THESE SYMPTOMS SHOULD BE ISOLATED IN BED PENDING DIAGNOSIS. EARLY MEDICAL CARE is extremely important.

4. Avoid undue fatigue and exertion during the polio season.

5. AVOID UNNECESSARY TRAVEL AND VISITING IN AREAS WHERE POLIO IS KNOWN TO BE PREVALENT.

6. Pay special attention to practice of good personal hygiene and sanitation:

   a.) Wash hands before eating.

   b.) Keep flies and other insects from food.

   c.) Cover mouth and nose when sneezing or coughing.

SURGICAL PROCEDURES

1. Nose, throat or dental operations, unless required as an emergency, should *not* be done in the presence of an increased incidence of poliomyelitis in the community.

GENERAL SANITATION, INCLUDING FLY CONTROL

1. Although there has been no positive evidence presented for spread of poliomyelitis by water, sewage, food, or insects, certain facts derived from research indicate that they *might* be involved in the spread.

   a.) *Water*—Drinking water supplies can become contaminated by sewage containing poliomyelitis virus. While no outbreaks have been conclusively traced to drinking water supplies, only water from an assuredly safe source should be used to prevent any possible hazards that might exist.

   b.) *Sewage*—Poliomyelitis virus can be found for considerable periods of time in

bowel discharges of infected persons and carriers and in sewage containing such bowel discharges. Proper collection and disposal facilities for human wastes are essential to eliminate the potential hazard of transmission through this means.

c.) *Food*—The infection of experimental animals by their eating of foods deliberately contaminated with poliomyelitis virus has been demonstrated in the laboratory, but no satisfactory evidence has ever been presented to incriminate food or milk in human outbreaks. Proper handling and preparation of food and pasteurization of milk supplies should reduce the potential hazard from this source.

d.) *Insects*—Of all the insects studied, only blow-flies and house flies have shown the presence of the poliomyelitis virus. This indicates that these flies might transmit poliomyelitis. It does not show how frequently this might happen; it does not exclude other means of transmission; nor does it indicate how important fly transmission might be in comparison with other means of transmission.

2. Fly eradication is an extremely important activity in maintaining proper sanitation in every community.

3. Attempts to eradicate flies by spraying of effective insecticides have not shown any special effect upon the incidence of polio in areas where it has been tried. Airplane spraying is not considered a practical and effective means in reducing the fly population of a city. The best way to control flies and any of the diseases they may spread is to eliminate fly breeding places. Eradicate flies by:

a.) Control of manure piles by construction, spreading, and/or spraying to prevent fly breeding.

b.) Proper storage, collection, and disposal of garbage and other organic waste.

c.) All privies should have both fly and rodent-proof pits.

Proper sanitation should be supplemented by using effective insecticides around garbage cans, manure piles, privies, etc. Use effective insecticide spray around houses or porches or paint on screens to kill adult flies.

SWIMMING POOLS

1. Unsatisfactorily constructed or operated swimming pools should be closed whether or not there is poliomyelitis in the community.

2. On the basis of available scientific information, the State Department of Public Health has no reason to expect that closure of properly equipped and operated swimming pools will have any effect on the occurrence of occasional cases of poliomyelitis in communities.

3. In communities where a case of poliomyelitis has been associated with the use of a swimming pool, that pool and its recirculation equipment should be drained and thoroughly cleaned. (The State Department of Public Health should be contacted for specific cleansing procedures). After these measures, the pool is ready for re-opening.

4. Excessive exertion and fatigue should be avoided in the use of the pool.

5. Swimming in creeks, ponds and other natural waters should be prohibited if there is any possibility of contamination by sewage or too many bathers.

SUMMER CAMPS

Summer camps present a special problem. The continued operation of such camps is contingent on adequate sanitation, the extent of crowding in quarters, the prevalence of the disease in the community and the availability of medical supervision. Full information is available from the Illinois Department of Public Health to camp operators and should be requested by the latter.

1. Children should not be admitted from areas where outbreaks of the disease are occurring.

2. Children who are direct contacts to cases of polio should not be admitted.

3. The retention of children in camps, where poliomyelitis exists, has not been shown to present increased hazards to these children. Furthermore, return of such children to their homes may introduce the infection to that community if it is not already infected. Similarly, there will be no introduction of new contacts to the camp and supervised curtailment of activity will be carried out, a situation unduplicated in the home. This retention is predicated upon adequate medical supervision.

4. If poliomyelitis occurs in a camp it is advisable that children and staff remain there, (with the exception of the patient, who may

be removed with consent of the proper health authorities). If they do remain:

a.) Provide daily medical inspection for all children for two weeks from occurrence of last case.

b.) Curtail activity on a supervised basis to prevent overexertion.

c.) Isolate all children with fever or any suspicious signs or symptoms.

d.) Do not admit new children.

SCHOOLS

1. Public and private schools should not be closed during an outbreak of poliomyelitis, nor their opening delayed except under extenuating circumstances and then only upon recommendation of the Illinois Department of Public Health.

2. Children in school are restricted in activity and subject to scrutiny for any signs of illness. Such children would immediately be excluded and parents urged to seek medical attention.

3. Closing of schools leads to unorganized, unrestricted and excessive neighborhood play. Symptoms of illness under such circumstances frequently remain unobserved until greater spread of the infection has occurred.

4. If poliomyelitis occurs or is suspected in a school:

a.) The child should immediately be sent home with advice to the parents to seek medical aid, and the health authority notified.

b.) Classroom contacts should be inspected daily for any signs or symptoms of illness and excluded if these are found.

HOSPITALS

1. There is no reason for exclusion of poliomyelitis cases from general hospitals if isolation is exercised — rather, such admissions are necessary because of the need for adequate medical care by the patient.

2. Patients should be isolated individually, or with other cases of poliomyelitis in wards.

3. Suspect cases shall be segregated from known cases until the diagnosis is established.

4. The importation of cases to hospitals in a community where poliomyelitis is not prevalent has not been demonstrated to affect the incidence of the disease in the hospital community.

RECREATIONAL FACILITIES

1. Properly operated facilities for recreation should not be closed during poliomyelitis outbreaks.

2. Supervised play is usually more conducive to restriction of physical activities in the face of an outbreak.

3. Playground supervisors should regulate activities so that overexertion and fatigue are avoided.

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## Amendment to "RULES AND REGULATIONS FOR THE CONTROL OF COMMUNICABLE DISEASES"

(Revised and in force throughout Illinois, Sept. 1, 1945)

*Page* 36: Amending the rules and regulations for the control of *POLIOMYELITIS, ACUTE ANTERIOR* as follows:

*"Control of Case*

(1) Placarding is *not* required.

(2) Isolation is required for *one* week from date of onset and thereafter until temperature is normal for 24 hours.

(3) Concurrent disinfection is required.

(4) Terminal disinfection is required.

*"Control of Contacts*

(1) No restrictions. It is recommended that children with direct contact to a case be kept under medical surveillance for two weeks from date of last exposure. Voluntary limitation of physical activity to reduce severity of disease if it should develop is also recommended.

*"Sale of Milk and Milk Products*

(1) Adult home contacts, who are engaged in the production of milk and milk products on the premises in which a case is isolated, may continue such production *provided* that all milk and milk products are sent directly to a pasteurizing plant.

*"General Measures during Outbreaks*

(1) General warning to physicians and the laity of the prevalence or increase of incidence of the disease, description of usual characteristics of onset, and necessity for early diagnosis and medical care.

(2) All children with fever should be isolated in bed pending diagnosis.

(3) Avoid undue fatigue and exertion during the polio season.

(4) Avoid unnecessary travel and visiting in

(*Continued on page* 112)

# ORIGINAL ARTICLES



# Transurethral Resection of the Prostate Gland

**J. Byron Beare, M.D. and Carl A. Wattenberg, M.D.**
**St. Louis, Mo.**

The development and perfection of the transurethral method of operation for the relief of urinary obstruction as a result of prostatic enlargement has been one of the most noteworthy advances in modern urology. The use of this method has resulted in a marked lowering of the immediate post-operative mortality, much less discomfort for the patient, earlier ambulation, and a greatly decreased number of hospital days, this last resulting in less expense to the patient.

Because this type of operation has been and can be applied in a much wider scope than originally was thought possible, one now can offer relief to the extreme aged, the debilitated and the poor risk patients who in years past have been forced to lead a permanent catheter type existence.

One hundred consecutive cases of prostatic obstruction have been operated by the transurethral method. The Thompson resectoscope was used exclusively. Ninety-one of the hundred cases had benign prostatic hyperplasia and nine had adenocarcinoma.

The maximum age of the hundred cases was 89 years, and the average age was 65.5 years.

*Pre-Operative Management.*—The elderly patient with prostatic obstruction should be taken care of differently than the younger one. Obviously, confinement in bed is not recommended, as this tends to lower the blood pressure with resultant predisposition to vascular accidents.

Catheter drainage is not used unless the patient enters in acute retention and surgical intervention must be delayed thirty-six to forty-eight hours in order to complete the general examination, or unless he shows a renal insufficiency as indicated by an elevated blood urea or NPN. In this regard, one need wait only until the man can take 2500 to 3000 cc. by mouth. Parenteral fluids need not be administered if the man can take 2500 to 3000 cc. by mouth. In the event that intravenous fluids are used, we feel that five per cent glucose in water is sufficient, since it is easy to over-load the system with NaCl which might result in retention of

From the Dept. of Surgery, Washington University School of Medicine, St. Louis, Missouri.

water in the tissues. In all cases of elevated urea, one must pay particular attention also to the acid-base equilibrium, as evidenced by the $CO_2$ combining power. By the judicious use of Hartman's solution, or $NaH\ CO_3$, one can supply sufficient base to combine with the excess urea, even if the patient is quite acidotic.

A cystoscopic examination should be carried out immediately prior to resection in all patients in which the diagnosis can be established positively by the history and physical examination alone. Only those patients concerning whom there is some doubt as to the need for resection should be subjected to the two procedures at separate times. Perhaps one exception to this rule is the case of the extremely bad risk in which time is all important. In this group the five minutes under anesthesia needed for cystoscopy can better be used to resect. In addition, one can determine how the patient will react generally to an extremely small amount of anesthesia and simple cystoscopy. It gives some idea as to how he will tolerate the resection, as well as guides the surgeon in his plan for treatment and surgery.

In our opinion, the vas deferens should be ligated bilaterally in all cases. Perhaps there are those who do not agree, but we feel that the two to three minutes required to carry out this simple procedure are justified in that it prevents epididymitis as a complication regardless of how low the percentage of such a complicating factor may be.

A careful work-up should be carried out by the internist prior to surgery. Especially is this true of the patient who is an extremely bad risk. However, it has been our experience that these elderly men tolerate surgery much better within the first forty-eight hours after admission than they do at a later date, and because of this we prefer to operate within that time, unless some definite reason is found for delaying the resection.

*Operation.*—With few exceptions we have used pentothal anesthesia, supplemented with nitrous oxide and oxygen. Proper use of the latter agents enables one to use less pentothal, and consequently most patients awaken on the table before being returned to their rooms.

The technique of resection is now well standardized. All recognize the fact that cutting a gutter or channel through the prostatic urethra is entirely inadequate and that the post-operative results are disappointing. One can state emphatically and without fear of contradiction that the success of transurethral prostatic resection is directly proportional to the completeness of removal of the prostate. By far the great majority of patients who have untoward post-operative symptoms are those who still have prostatic tissue remaining. These are also the ones who develope a recurrence of symptoms some twelve to eighteen months post-operatively.

Because the risk of operation among elderly patients varies in direct proportion to the time consumed, time of operation must be short. Such patients tolerate two fifteen-minute procedures two to three days apart, while in many instances they may not survive one thirty-minute procedure. Blood loss should be kept at an absolute minimum and if more than normal bleeding does occur, the blood pressure must be maintained with glucose, plasma or blood.

Post-operative strictures can and should be prevented rather than treated, first of all by the use of proper-sized instruments. Meatotomy must be carried out if the meatus will not admit easily the 30 Fr. sound. Actually, the entire urethra should dilate easily to 30 Fr. for the most adequate handling of the instrument. Proper lubrication of instruments and care in passing these through the urethra will help prevent strictures.

A strict aseptic technique is necessary and important. Certainly one will find a much higher percentage of post-operative febrile reactions in those patients in which there has been careless asepsis.

We have been entirely satisfied with water as an irrigating solution during operation, as long as the water pressure is not too high, and with N-saline as a post-operative irrigating solution.

*Post-Operative.*—We prefer to use a three-way Foley type catheter and institute continuous closed irrigation for the first twenty-four hours. This will not permit one to be careless about hemostasis, but it does keep the patient comfortable, lessen the nursing problem and minimize the chances for gross contamination of the operative site post-operatively. We prefer to use a 24 Fr. catheter and not change it until we are ready to have the patient void.

With very few exceptions all patients are out of bed and sitting in a chair the day after sur-

gery. We always allow the catheter to drain and never cork it up. Early ambulation of patients cannot be over-emphasized.

The catheter generally is removed in forty-eight to seventy-two hours and in most cases the patient voids with a freedom he has not known for some time. Obviously, if there is any difficulty the catheter should be re-inserted for forty-eight hours and the patient given another trial. If there is still difficulty, one should perform another cystoscopic examination and be prepared to remove more tissue since that will be the cause of the trouble in most cases.

Within forty-eight hours after the catheter has been removed the patient can be discharged to his home. It is advisable for the patient to remain within easy access to the urologist for the first twelve to fourteen post-operative days. Some patients who live a long way from the city prefer to remain in the hospital for the entire period.

After two weeks post-operative care, bleeding can well nigh be forgotten because with the Thompson type resectoscope one does not have any secondary slough and bleeding. Most patients continue to improve and arrive at the stage of maximum benefit in six to eight weeks, at which time the urine should be entirely free of infection. If this is not true, a short course of chemotherapy will clear up the infection promptly. We do not check for residual urine post-operatively until the fourth week.

In a large series of transurethral prostatectomies published by G. J. Thompson[1], it was found that in patients with adenomatous enlargement five per cent had a recurrence of symptoms in ten years. This seems very negligible when one remembers the average life expectancy of this age group of patients.

In this group of one hundred cases, there was one death. This emphasizes that with careful management transurethral prostatectomy can be performed with much less risk than any other type of prostatic surgery. The patient who died had severe syphilitic heart disease and a neurogenic bladder. He was quite debilitated and we feel sure the forty-five minutes of surgery was too much for him. If the procedure had been divided, he might have survived.

In conclusion, we feel that the results of transurethral resection at the hands of an experienced surgeon are superior to those obtained by any other type of prostatic surgery.

REFERENCES

1. Thompson, G. J. and Habein, H. C.: Transurethal Prostatic Resection. A Review of 1200 Cases of Patients More Than Seventy Years Old. Am. J. Surg. N. S. 45:27-32. July, 1939.

## COMMUNICABLE DISEASES (Continued)

areas where polio is known to be prevalent.

(5) Nose, throat and dental operations, unless required as an emergency, should *not* be done in the presence of an increased incidence of the disease in the community."

STATE OF ILLINOIS
COUNTY OF SANGAMON

I, Roland R. Cross, M.D., Director of the Department of Public Health, State of Illinois, do hereby certify that the foregoing rules as amending the "RULES AND REGULATIONS FOR THE CONTROL OF COMMUNICABLE DISEASES, Revised and in force on and after September 1, 1945, throughout Illinois," as herein set forth, are a true and correct copy of rules promulgated by the Department of Public Health effective on and after the 22nd day of June, 1950.

IN WITNESS WHEREOF, I hereunto set my hand and Official Seal of the Department of Public Health of the State of Illinois, this 22nd day of June, 1950. Roland R. Cross M.D. Director of Public Health.

# Local Antihistaminic Agents in Ophthalmology

**Paul Hurwitz, M.D.**
**Chicago**

The antihistominic agents, by virtue of their pharmacologic actions of vasoconstriction, mild surface anesthesia, excellent absorption and ability to counteract the affects of histamine, are ideally adapted for ophthalmic use.

In a previous report[1], I indicated the beneficial effect of Antistine ophthalmic solution in a series of ocular allergies. Though the mechanism of the specific action of the antihistaminics is not definitely known, the accepted theory is that it either replaces the space in the cell that would be occupied by histamine, or otherwise prevents histamine from getting to the cell. Chemical neutralization is not considered likely. What may be the most effective factor is the antihistaminic potential of decreasing capillary permeability, thus placing an impermeable barrier between histamine and the cell. The purpose of this report is to briefly summarize the effect of the local antihistaminic agents in various ocular conditions.

There are in current use many antihistaminic agents. Only one preparation, Antistine, is available on the market as an ophthalmic solution. Others are being studied. One of these, Histadyl Hydrochloride, will be discussed in this paper, concurrent with Antistine.

This study deals with the symptomatic response to these drugs (Antistine and Histadyl solutions and ointment) in cases of chronic catarrhal conjunctivitis, epiphora of non-pathologic origin, ocular asthenopia and five groups of ocular allergy. The predominant symptoms in these patients were ocular itching, tearing, redness, mucous secretion, burning sensation and photophobia. Included are one hundred cases.

## ANTISTINE

Antistine solution for ocular topical application contains the hydrochloride in 0.5% concentration with a PH of 6.9 in an isotonic buffered solution.* The Antistine ophthalmic ointment is prepared in 0.25% strength with a petrolatum base. These preparations plus a 3% Antistine cream were used in the following series of patients. The ophthalmic ointment is as yet not available on the market.

## OCULAR ALLERGIES

In this category are seventy-eight patients with allergic ocular conditions, arbitrarily divided into five groups —i.e.— allergic conjunctivitis in hay fever; allergic conjunctivitis, iritis and keratitis in cases of hay fever plus other allergens; allergic conjunctivitis, blepharitis and keratitis with allergens other than the pollens; vernal conjunctivitis; and allergic palpebral dermatitis and urticaria.

1. *Allergic Conjunctivitis with Hay Fever*— In eighteen cases of simple allergic conjunctivitis in typical hay fever, Antistine ophthalmic solution was used locally. Marked relief was obtained from ocular itching, lacrimation, redness, photophobia, visual blurring and blepharospasm. Local instillations of one drop daily to one drop three times a day were required to obtain relief. The only untoward reaction consisted of a temporary smarting or burning sensation of varying degree. Generally, the pathologic processes of conjunctival hypertrophy, edema and hyperemia were only mildly influenced, indicating that the effect of the local antihistaminics is primarily palliative. There were, nonetheless, a number of patients who showed pathologic improvement. In this series of eighteen cases, symptomatic improvement occurred in all but one.

*Case Report.*—Typical of this series is Mrs. S.F., who annually suffered with hay fever. Skin tests revealed hypersensitivity to ragweed pollen. The ocular

1. Hurwitz, Paul: "Antistine In Ocular Allergy", Amer. Jour. Ophthalmology, Vol. 31, No. 11, Nov. 1948

*Formula of Antistine Ophthalmic Solution

| | |
|---|---|
| Antistine HCL | 18.75 gm. |
| Sodium carbonate anhydrous | 2.66 gm. |
| Boric acid U.S.P. | 46.50 gm. |
| Potassium chloride | 27.75 gm. |
| Distilled water | 3750.00 gm. |

symptoms were itching, lacrimation and redness. Innumerable drugs gave only fleeting relief. One drop of Antistine Solution, instilled in both eyes each morning, gave complete relief from the ocular symptoms for the entire day.

2. *Allergic Conditions with Combined Allergic Etiology.* — In ten cases there was present hypersensitivity to ragweed pollen and other perennial allergens. The pathologic conditions consisted of allergic conjunctivitis in its simple state and also associated with hordeolii, superimposed acute conjunctivitis, recurrent iritis and keratitis. The symptoms consisted of ocular itching, tearing, redness, photophobia and blepharospasm. Nine of these ten patients experienced substantial symptomatic relief with the use of Antistine solution.

*Case Report.*—Typical of this group is a boy with a familial history of allergy. He had perennial itching, tearing and redness of both eyes. During the hay fever season the symptoms were aggravated. The pathology consisted of pale boggy palpebral conjunctivae and phlyctenular keratitis. Antistine ophthalmic solution, instilled three times daily, relieved the symptoms and the pathology subsided.

3. *Allergic Conditions Other Than Of Hay Fever Origin.* — In this group are twenty-four cases of ocular allergy in which hypersensitivity to ragweed pollen was not considered a factor. These were essentially perennial allergies. The pathologic states included allergic conjunctivitis, ulcerative and squamous blepharitis and phlyctenular keratitis. The symptoms were itching, burning and mucous discharge from both eyes. Nineteen of these twenty-four patients were moderately to completely relieved symptomatically with Antistine Solution. In some patients pathologic improvement was noted.

*Case Report.*—Characteristic of this group is a young woman who complained of itching and mucoid discharge of both eyes, associated with sneezing. The conjunctival scraping revealed a 20% eosinophilia. Antistine solution instilled three times a day relieved the itching and eliminated the discharge almost entirely.

4. *Vernal Conjunctivitis.* — In five cases of vernal catarrh, symptomatic relief was obtained with the use of Antistine solution. Though no pathologic improvement was evident in any of these cases, there was a moderate to marked decrease in the photophobia, discharge, tearing and itching. Antistine solution had to be used three to four times daily.

*Case Report.*—A girl complained of itching and discharge from both eyes. There was a marked swelling and redness of the palpebral conjunctivae of all four lids with cobble stone hypertrophy. Antistine solution used every three hours relieved the itching. After a period of two weeks the secretion abated and the acuteness of the condition subsided. Chronic hypertrophy remained.

5. *Allergic Dermatitis and Urticaria* — Twenty-one patients with allergic palpebral dermal conditions were treated variously with 0.25% Antistine ophthalmic ointment, 0.5% Antistine ophthalmic solution or 3% Antistine cream. The group included nine cases of eczematoid (contact) dermatitis secondary to sulphathiazol ointment, penicilin ointment or finger nail polish; nine cases of allergic urticaria; two cases of angioneurotic edema and one case of palpebral pruritis. Seventeen of the twenty-one patients were substantially or completely relieved symptomatically and pathologically.

Striking improvement in the pathologic status was demonstrated in the cases of eczematoid dermatitis. This was undoubtedly due to the immediate relief from itching, ensuing improvement in the absence of irritative phenomena, the antagonist effect on the histaminic action, plus, of course, the withdrawal of the offending allergen. In the dermal conditions, the 0.25% ophthalmic ointment proved most effective. The 3% cream caused excessive burning and had to be discontinued in all cases. The ophthalmic solution relieved only the conjunctival symptoms, when instilled occularly. Saturated pads of the solution applied as compresses proved inadequate.

*Case Report.*—Typical of this group is a woman patient who suffered from itching, thickening and scaling of the skin of the upper lids. She also had an eczematoid lesion behind one ear, which had been resistant to numerous forms of therapy. The history revealed a number of food allergies. Application of Antistine ophthalmic ointment to the skin of the lids resulted in immediate relief of the itching and a subsidence of the pathology within a week. Similar treatment to the eczematoid dermatitis behind the ear effected a cure in four days.

Indicative of the fact that the capillary permeability is decreased by the antihistaminics is a case of palpebral angioneurotic edema, which rapidly subsided following the instillation of Antistine solution. In another patient, with vesicles of the bulbar conjuctivae, the instil-

lation of Antistine solution resulted in a disappearance of the vesicles, but only for as long as the solution was continued.

## OCULAR CONDITIONS OTHER THAN ALLERGY

Since the local application of the antihistaminic agents were effective in relieving the symptoms of itching, burning and tearing in allergic cases, it was believed to be worth experimentation in other (non-allergic) conditions where similar symptoms were present.

*Chronic Catarrhal Conjunctivitis.* — Accordingly, thirteen cases of chronic catarrhal conjunctivitis were selected, which were symptomatically resistant to other drugs. Predominant symptoms in this group were itching, burning, tearing, foreign body sensation and ocular discomfort. No allergic factors were manifest in these cases. The existing pathology was principally thickening and hyperemia of the palpebral conjunctivae. Bacterial classification was not attempted. Through the use of Antistine solution, symptomatic improvement was obtained in ten of the thirteen cases. The most marked improvement was the relief from the itching. Since most of the patients had used numerous medications without relief, it indicates that the Antistine solution was of value. The prolonged period of relief obtained signifies that this effect was not dependent on the mild anesthetic and decongestant properties of the Antistine.

Since the antihistaminics are presumed to act in a specific manner, a consideration is that the itching may be the result of a sensitization of the nerve endings by the elaboration of histaminic end products due to the inflammation or conjunctival irritation. Inactivation of these end products, or their preclusion to the cells by the antihistaminics locally, may be the action by which itching is obviated.

*Epiphora.* — Since Antistine solution resulted in a decrease of the lacrimation of hay fever conjunctivitis, it was used in five cases of epiphora in which no pathologic or etiologic factor could be determined. These cases might be termed "functional" epiphora. All were middle aged or elderly, emotionally unstable women. Antistine solution in these cases resulted in no improvement whatsoever.

*Asthenopia.* — Interesting results were obtained in two patients with asthenopia, who complained bitterly of ocular itching associated with prolonged close work. No pathology was present except for corrected refractive errors. With the use of Antistine solution both patients experienced prolonged and marked relief. Although two cases are inadequate evidence upon which to support the contention that Antistine is of value in this type of case, its use can be initiated without harm.

## HISTADYL HYDROCHLORIDE

Histadyl hydrochloride (thenylpyramine hydrochloride in 0.5% solution and in 0.5% and 1.0% ointment for ocular use is available for experimental purposes. The solution and ointment were used in a group of seven cases of ocular conditions to determine the efficacy of Histadyl hydrochloride and its comparative value to Antistine.

The Histadyl in a physiological saline solution was used in three cases, i.e. — vernal conjunctivitis with secretion and itching, chronic conjunctivitis with itching, and allergic conjunctivitis with itching. All three cases experienced moderate symptomatic relief, but all complained of severe burning when the solution was instilled. It is likely that a buffered solution, prepared for ocular use, would be of value, but in its present state, it is too irritating.

Four patients with allergic palpebral urticaria were given 0.5% and 1.0% Histadyl ophthalmic ointment for dermal and conjunctival use. Three patients promptly developed an eczematoid (contact) palpebral dermatitis. Review of the records of the three patients revealed a hypersensitivity to lanolin. It was then discovered that Histadyl ointment is prepared in a lanolin and petrolatum base.* This obviously makes the ointment undesirable since lanolin hypersensitivity is not rare. (Investigation also reveals that a percentage of the contact reactions attributed to ophthalmic drugs such as penicillin, sulphathiazol and mercurials in ointments are actually due to the lanolin vehicles in these ointments.) All three patients promptly responded to a withdrawal of the Histadyl ointment and the application of Antistine ointment.

The 1.0% Histadyl ointment caused excessive burning sensation. In this aspect, the 0.5% ointment was well tolerated.

*In a personal communication, the manufacturer states that work is in progress on a greaseless base for Histadyl ophthalmic ointment.

COMPILATION OF CASE REPORTS

| | Symptoms | | |
|---|---|---|---|
| | No. | Improved | Not Improved |
| Allergic Conjunctivitis with Hay Fever .. | 18 | 17 | 1 |
| Allergic Conjunctivitis, Blepharitis and Keratitis without Hay Fever ..... | 24 | 19 | 5 |
| Allergic Conjunctivitis, Blepharitis, Iritis, and Keratitis with Hay Fever and Other Allergens ..... | 10 | 9 | 1 |
| Vernal Conjunctivitis ..... | 5 | 5 | 0 |
| Catarrhal Conjunctivitis Acute and Chronic | 13 | 10 | 3 |
| Allergic Palpebral Dermatitis and Urticaria | 23 | 18 | 5 |
| Epiphora Functional ..... | 5 | 0 | 5 |
| Ocular Asthenopia with Itching ..... | 2 | 2 | 0 |
| Totals ..... | 100 | 80 | 20 |

CONCLUSIONS

1. The results of the local use of the antihistaminic agents in one hundred ocular cases are briefly summarized.

2. Antistine ophthalmic solution and ointment locally employed are of decided symptomatic palliative value in the ocular allergies and in symptomatic ocular itching of other origin.

3. Histadyl hydrochloride in solution and ointment used in seven cases was found to be less effective than Antistine.

4. Eighty percent of one hundred selected ocular conditions were symptomatically improved with local antihistaminic therapy.

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# Management of Abortions

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The most critical period during pregnancy lies between the 10th and 16th week of gestation. At this time several important changes take place. First, there is a shift of hormonal responsibility from the corpus luteum to the placenta; second, the enlarging amniotic sac makes contact with the opposite side of the uterine wall and seals off the uterine cavity from the cervical canal and vagina; and third, the uterus at this point is about the size of a grapefruit and has reached the brim of the true pelvis, to become an abdominal organ as well as a pelvic structure.

It is easy to see how, even under ideal circumstances, the products of conception and their corresponding implantation bed would be subjected to changes and irritations of a potentially serious nature. When interference with the hormonal shift of responsibility from the corpus luteum to the placenta develops, whether that interference is localized in the ovary or placenta, or in the pituitary governing mechanism, a real invitation to abortion takes place. When contact of the amnion with the opposite uterine wall is impeded, either through a defect in the amniotic sac or in the endometrium, abortion is possible. When the expanding and rising uterus meets with obstruction as it approaches or passes the pelvic brim, abortion may occur. There will be occasions when all three of these conditions are present and then abortion is inevitable.

The number of pregnancy accidents which begin as threatened abortion and progress to complete or incomplete or missed abortion is impressive. One out of every nine pregnancies end in abortion. Many early accidents undoubtedly occur without the woman so much as suspecting her misfortune. Few women escape the experience during their active sex life.

A number of physicians believe abortion is always the result of abnormal fetal development. There is some evidence to support this idea. Pathological studies indicate that abortion, before the third month, is predominantly the result of imperfect fetal growth, but eight out of nine fetuses are normal at the end of the third month. It may be concluded, therefore, that

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abortion which occurs early in pregnancy is the result of defective germ plasm, but when developing after the third month is due mainly to disturbances of the implantation site. Rarely is a fetus at birth found to be defective, following hormonal therapy which began not earlier than the third month of pregnancy.

Abortion accidents may be grouped as follows:

1. Threatened abortion
2. Habitual abortion
3. Complete abortion
4. Incomplete late abortion
5. Incomplete early abortion
6. Missed abortion.

Obviously, a *complete* abortion closes the episode so far as the management of that particular pregnancy is concerned, unless the abortion is accompanied by hemorrhage or infection; in which case appropriate blood infusions, iron support and antibiotics should be used. The *incomplete early abortion* may be completed by recourse to oxytocic drugs but a certain number will require surgical intervention. When hemorrhage is severe, the uterus should be emptied at once, even in the presence of infection. This is done preferably by a dull curette or ovum forceps, occasionally using the finger, occasionally inserting a thin uterine pack, removed in 24 hours. The availability of sulfa and penicillin permits more aggressive action in such cases than was deemed wise formerly. At the Cook County Hospital from 1943 to 1945, there were 975 early incomplete abortions with four deaths. When it is recalled that the County Hospital is frequently the dumping ground for all kinds of pathology, including a large number of infected incomplete abortions, that record is outstanding. It is the procedure there to empty the uterus harboring an incomplete early abortion, septic or non-septic, within a relatively short time after admission.

The *incomplete late abortion*, occurring after the 12th week of pregnancy, is a different story. Because of a larger uterus and a functioning placenta, danger from hemorrhage and infection are greater than in early incomplete abortion. Failure of oxytocic drugs to expel the remaining products of conception, in the presence of active bleeding, nonetheless calls for surgery. Vaginal emptying of the uterus is the procedure of choice with the patient well fortified by antibiotics and blood. *Missed abortion*, sometimes called 'bloody mole' should not be cause for alarm. It seldom exists longer than three months and nature will as a rule expel the undesired tenant. However, a missed abortion existing longer than three months, should be removed by vaginal or abdominal hysterotomy. If the symptoms of toxic absorption appear, the uterus should be emptied at an earlier date by dilatation and evacuation.

While the management of incomplete and missed abortion has been simplified by the advent of antibiotics and more frequent use of blood transfusions, a similar statement cannot be made for threatened and habitual abortion. These pregnancy accidents are still encircled by a shroud of mystery. It is the contention of some that all threatened abortions are due to defective germ plasm. Others are equally convinced that many abortions are secondary to an imbalance of pregnancy hormones. Extensive studies have been conducted to show that the hormones chiefly concerned with keeping pregnancy on the upgrade are estrogen and progesterone.

There seems to be no disputing the fact that estrogen is imperative for the proper growth of the endometrium and progesterone is required for satisfactory implantation of the fertilized ovum and thereafter, for keeping the uterus in a quiescent state. What is not known, however, is how much of these hormones is necessary, first, to establish pregnancy and from then on to keep the pregnancy going; neither is it known in what proportion estrogen and progesterone circulate within the human organism; nor is it known if one hormone is capable of being converted into the other.

At the present time, threatened and habitual abortion are managed by one or a combination of the following methods:

1. Watchful Waiting
2. Vitamins
3. Thyroid
4. Progesterone
5. Progesterone and estrogen
6. Estrogen

*Watchful Waiting*: This method is followed by men who are for the most part practical and realistic. Many of them have watched the ebb and flow of panaceas and cure-alls for a long time, and have come to the cynical conclusion

that any treatment of threatened and habitual abortion is contrary to nature and is doomed to failure.

*Vitamins*: There is experimental and clinical evidence to support the belief that vitamin E is necessary for proper implantation of the fertilized egg and for that reason vitamin E is recommended in cases of habitual abortion. Vitamin C and vitamin D have also been used with conflicting reports.

*Thyroid Therapy*: Although no experimental data is available to support the contention that the thyroid gland is at fault in habitual abortion, thyroid is advocated as a rule, in doses of ½ to 1 grain daily.

*Progesterone*: The use of progesterone to combat threatened and habitual abortion was strengthened by the discovery of a urinary excretion product called pregnandiol, taken to be an end result of progesterone metabolism. It was shown that no pregnandiol is excreted during the first half of the menstrual cycle when the corpus luteum is absent, but is excreted during the last half when the corpus luteum is developing. It was further demonstrated that no appreciable increase of pregnandiol takes place during the first 90 days of gestation over that seen during the last half of the normal menstrual cycle, but from the 90th day on there is a steady increase up to the last weeks of pregnancy. This observation strongly supported the impression that the placenta took over the function of the corpus luteum at about the 90th day of gestation and from then on was responsible for the maintenance of pregnancy through the production of estrogen and progesterone. At a later date it was shown that in threatened and habitual abortion the amount of pregnandiol excreted fell below the figures accepted for normal pregnancy, and hence, it was reasoned, the administration of progesterone should control early pregnancy accidents.

Three forms of progesterone therapy are advocated at the present time.

1. Animal progesterone
2. Aqueous corpus luteum
3. Synthetic pranone

*Animal progesterone* is recommended for threatened abortion in doses of 10 to 20 mgms. injected every 4 to 6 hours, reduced gradually to 10 mgms. bi-weekly to the 36th week of pregnancy. For habitual abortion 10 mgms. bi- weekly to the 36th week.

*Aqueous corpus luteum* is effective in 12 to 24 cc. intravenous doses at the onset of bleeding and cramps and then 3 cc. intramuscularly every 3-4 hours, reduced gradually to 3 cc. every 6-8 hours, thence to 3 cc. daily and when the patient is discharged from the hospital, 3 cc. bi-weekly to the 36th week. For habitual aborters, 3 cc. bi-weekly to the 36th week.

*Pranone* is an oral synthetic progesterone and is taken to have about one-fourth the potency of animal progesterone. The suggested dose is 100 to 150 mgms. daily for threatened abortion, reduced gradually as the symptoms subside to 10 to 30 mgms. daily thereafter, to the 36th week. In habitual abortion, 10 to 30 mgms. daily to the 36th week.

*Progesterone and Estrogen*: Following the pioneer work with progesterone, other investigators began experimenting with the use of estrogen in combination with progesterone since it was found that a drop in pregnandiol output, was accompanied frequently by a fall in estrogen excretion as well. They saw an overall improvement, both in the clinical response and in the amount of pregnandiol excreted, following the administration of estrogen and progesterone together. This phenomenon was difficult to explain, unless the estrogen in some way enhanced the production or metabolism of progesterone. The question was then asked, if better results are obtained by using a combination of estrogen and progesterone, what will happen if estrogen is given alone? This was a revolutionary thought, because up to then estrogen and progesterone were generally believed to be antagonistic to one another.

*Estrogen*: After a series of studies based on the administration of diethylstilbestrol to threatened and habitual abortion cases, it was found that the output of pregnandiol exceeded the quantity obtained when either progesterone alone or in combination with estrogen was given, and the number of clinical responses was equally impressive. This group of investigators then came forth with the amazing hypotheses, that the improvement in clinical symptoms and the increased production of pregnandiol was not due to estrogen directly, but rather to the fact that estrogen stimulates the trophoblastic region of the placenta to produce more progesterone, hence

a reduction of uterine contractions and an amelioration of symptoms. Out of these observations, a rationale of stilbestrol therapy has evolved. For threatened abortion, 10 to 25 mgms of diethylstilbestrol is recommended every hour until symptoms cease, reduced thereafter to 5 mgms. three times daily to the 36th week. For habitual abortion, 5 mgms. three times daily beginning at the onset of pregnancy to the 36th week. The administration of as much as 200 mgms. daily of diethylstilbestrol has been reported without complaints. One clinic urges for habitual abortion, diethylstilbestrol in 5 mgms. doses starting with the 7th week of pregnancy, increased by 5 mgms. every two weeks to the 16th week, and increased thereafter by 5 mgms. every week to the 36th week at which time, the patient will be receiving 125 mgms. a day.

## DISCUSSION

Three obstacles confront any group of hormonal therapists;

1. Correct indication for the drug
2. Reliable dosage of the drug
3. Potential harm from the drug

*Correct Diagnosis*: At times it is difficult to distinguish between threatened abortion, inevitable abortion, incomplete abortion and a bleeding cervix. There is no means at hand which will accurately make this distinction at the onset of some bleeding cases. Occasionally, prolonged hormonal therapy is carried out in the presence of an unrecognized incomplete abortion, which has been incomplete from the beginning, yet was treated as a threatened abortion; sometimes that which is taken to be a threatened abortion is in reality an inevitable abortion; hormonal therapy is used, the patient aborts, and the case is included in the failure group; sometimes a bleeding eroded cervix is taken to be a threatened abortion; the cervix is not examined, the bleeding stops while hormonal therapy is in progress, and the patient is included in the salvages.

*Reliable Dosage*: Unfortunately at the present hormonal drugs, so that it can be said, so many time there is no reliable way to standardize these cc. of aqueous corpus luteum are equivalent to so many mgms. of pranone, and so many mgms. of pranone are equal to so many mgms. of progesterone and so many mgms of progesterone are equivalent to so many mgms of estrogen in their ability to supply the progesterone needed to manage pregnancy accidents. The dosage which is recommended has been adopted on the basis of animal experimentation, pregnandiol excretion and clinical response of the patient, methods which are known to be unreliable on occasions.

*Potential Harm*: Although estrogenic substances have been used by a number of authorities in the management of threatened and habitual abortions, there are several questions which should be answered before widespread approval is adopted? First; what effect will large doses of estrogen have upon the carcinogenic factor in woman. Second; what effect will large doses have upon the male fetus? Third; will large doses of estrogen cause latent liver damage in spite of the fact, no damage is apparent at the time of administration?

## CONCLUSIONS

The management of abortions, especially as it applies to threatened and habitual accidents, remains uncertain. Two hormonal methods of therapy have developed; methods which on the surface appear to be directly apposed to one another, yet when examined closely are very much alike. One belongs to the proponents of progesterone administration and the other to those who support estrogenic therapy. Each method advocates vitamin E, thyroid, bed rest and sedation as adjuvant measures. Those who rely on progesterone are quick to point out that the original concept of progesterone therapy has not been altered by the use of estrogen, since estrogen has for its prime objective, the elaboration of more progesterone, which hormone in the light of present knowledge is still the principal factor responsible for holding pregnancy together.

When a drug is advocated for an ailment as common as threatened and habitual abortion, not only must the medicant be effective, but it also must come within the budget of the average family. Therefore, it may be well to point out, that the cost of 150 mgms. of pranone, of 50 cc. of aqueous corpus luteum and of 40 cc. of progesterone is about the same, and is in the neighborhood of four dollars. The price of 150 mgms of the estrogenic substance, diethylstilbestrol, is less than a dollar. Given a condition which calls for therapy over a period of weeks and months, the cost factor might well become the deciding point as to the drug chosen, particularly if that drug can be given by mouth and if clinical reports following administration are of a favorable tone.

# Recent Developments in Endocrinology

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*Dr. Willard O. Thompson*: In the past few years important advances have been made in our knowledge of the thyroid, the pituitary, and the adrenal glands. The development of new investigative tools has added appreciably to our knowledge of their functions.

*The Pituitary And The Thyroid.* I shall confine my remarks principally to the relationship of the pituitary and the thyroid and to a consideration of developments that have occurred in the treatment of toxic goiter.

The anterior lobe of the pituitary produces thyrotropic hormone which stimulates the thyroid. It is a well-established fact that hypothyroidism may be either primary or secondary in type. The primary type is a result of some disturbance in the thyroid itself, and the secondary type is a result of the lack of adequate stimulation of the thyroid by the pituitary. It is probable, although not absolutely established, that primary and secondary types of hyperthyroidism occur. Hyperthyroidism, secondary to hyperpituitarism is not infrequently observed in patients with acromegaly. There are many reasons for believing that exophthalmic goiter is the result of overproduction of thyrotropic hormone by the anterior lobe of the pituitary. We have been interested in the effect of the thyrotropic hormone for several years and have made the following observations:

1. In patients with spontaneous myxedema and no functioning thyroid tissue the administration of thyrothropic hormone produces no effect.

2. In most patients with secondary hypothyroidism and in other patients with any thyroid tissue capable of stimulation, the administration of thyrotropic hormone will cause the metabolism to rise temporarily to a higher level. Some patients show no response at all and the amount of increase in basal metabolism varies greatly from patient to patient with the same dose of thyrotropic hormone. The increase in basal metabolism is temporary and, in our experience, has not lasted more than nine weeks. In spite of continued treatment, the basal metabolism returns to its original level or to a lower level with corresponding alterations in thyroid function.

3. Patients with non-toxic goiter may be made temporarily thyrotoxic and in patients with toxic goiter the severity of the disease may be increased.

4. In patients with normal or slightly subnormal levels of metabolism a syndrome resembling exophthalmic goiter may be induced with increase in basal metabolism, nervousness, tachycardia, increased perspiration, etc. In man, we have not been able to produce exophthalmos with thyrotropic hormone, but it has been produced in various experimental animals.

5. In some patients with toxic goiter we have been able to induce a complete remission following an initial exacerbation of the disease by continuing the administration of thyrotropic hormone until a so-called immunity to it developed.

*Treatment Of Toxic Goiter*—Three important developments have occurred.

1. The use of anti-thyroid drugs.
2. The use of radio-active iodine.
3. Irradiation of the pituitary.

*Anti-Thyroid Drugs.* A large number of anti-thyroid drugs have been used. The safest and the one most commonly administered is

propylthiouracil. These drugs have been used for medical management of the disease and for preoperative preparation of patients.

When used for medical management, propylthiouracil will induce permanent remission in at least 50% of patients when given under proper circumstances. The percentage of permanent remissions is too low to warrant its routine use in treatment. Most observers, therefore, feel that its application to the medical treatment of toxic goiter should be restricted to those patients who, for some reason, present poor operative risks.

It is of great value in the preoperative preparation of patients with thyrotoxicosis. By eliminating the hyperthyroidism completely the risk of operation is greatly reduced in patients who have the disease in moderately severe and severe form. In patients who have the disease in mild form it is debatable whether or not the routine administration of propylthiouracil is necessary. The preoperative use of this drug has resulted in an overall reduction in mortality from 1.0% to 0.1%.

In most clinics iodine is administered one week preceding operation to induce storage of colloid and to reduce the vascularity of the gland. In several clinics the administration of propylthiouracil is discontinued one week before operation to eliminate the possibility of any toxic effect from the drug at the time of operation.

*Radio-Active Iodine.* Radio-active iodine is an important therapeutic agent in various thyroid disorders and has been a valuable research tool for the study of thyroid physiology. It will produce a permanent remission in a large percentage of patients with toxic goiter but the dose varies greatly from patient to patient. It is sometimes necessary to give as many as three or four doses at intervals of eight to ten weeks.

Patients have not yet been followed long enough to provide adequate information concerning late complications, notably the developments of carcinoma. Up to the present time there are no data to suggest that radio-active iodine has caused carcinoma of the thyroid to develop in any patient. In some clinics it is being used routinely in the treatment of exophthalmic goiter but most observers are restricting its use to the treatment of patients who present poor operative risks, just as in the case of propylthiouracil.

It is of some interest that only about 13% of cancers of the thyroid take up enough radio-active iodine to make it an effective therapeutic agent. However, its uptake may be greatly increased by the administration of thyrotropic hormone or by stimulating the output of thyrotropic hormone by a surgical or functional thyroidectomy, using radio-active iodine itself.

*Irradiation Of The Pituitary.* We have been able to induce a complete remission in about one-third of the patients with toxic goiter by irradiation of the pituitary. These observations are of interest, principally, from the point of view of the mechanism involved in the production of the disease. The percentage of remissions is too low to warrant the routine use of pituitary irradiation.

*Nature Of Exophthalmic Goiter*—The evidence available indicates that exophthalmic goiter is a result of a complicated chain of events involving the thyroid, the pituitary, and the hypothalamus. Therapeutic effects directed at the thyroid alone, while very successful, may not attack the ultimate cause of the disease. Observations have been made recently on the possible role of the adrenal cortex in toxic goiter. In some patients the administration of ACTH will cause the basal metabolism to drop to normal temporarily, and some improvement has been reported in exophthalmos, presumably because of reduction in the amount of edema in the eyelids and in the tissues of the orbit. ACTH may produce its effect by inhibiting the anterior lobe of the pituitary. Further observations on this point are desirable.

*The Adrenal Cortex*—The evidence available indicates that the adrenal cortex has three important functions:

1. Control of sodium and potassium metabolism.

2. An influence on carbohydrate metabolism exerted primarily through the conversion of protein to carbohydrate.

3. Production of androgen. Under certain conditions, tumors of the adrenal cortex produce an excess of estrogen. However, such tumors are rare and there is not enough evidence at present to warrant the conclusion that the ad-

renal cortex plays an important role in estrogen production.

Observations have been made recently which demonstrate conclusively the important role of the adrenal cortex in body metabolism and in certain diseases. These observations have been made primarily with cortisone and with the adrenocorticotrophic hormone (ACTH).

The groundwork of these observations was laid as long as twenty or twenty-five years ago. Several years ago Kendall isolated compound "E" (cortisone) from the adrenal cortex. Interesting observations were made with this material but its true significance was not appreciated until early in 1949, when Kendall and Hench reported striking improvement in patients with rheumatoid arthritis, acute rheumatic fever, disseminated lupus erythematosus, and allergic asthma. There immediately followed interesting observations in various other diseases with both cortisone and ACTH.

The presence of an adrenal stimulating hormone in the pituitary had been demonstrated by Collip and others about twenty years ago. Purified adrenocorticotrophic hormone (ACTH) was isolated from the pituitary a few years ago by Evans and Li.

Following the report of Hench on the use of cortisone in various disease states, ACTH was immediately tried because it possessed the advantage over cortisone that it stimulated all functions of the adrenal cortex.

The administration of ACTH and cortisone have been shown to produce striking changes in the following diseases: rheumatoid arthritis, acute rheumatic fever, disseminated lupus erythematosus, allergic asthma, gout, dermatomyositis, periarteritis nodosa, allergic reactions of various types such as foreign protein reactions, pneumonia, pulmonary tuberculosis. The observations with ACTH and cortisone focused attention on the general adaptation theory of Selye. This theory was a description of what Selye considered to be the role of the adrenal cortex in various diseases. The effects of ACTH and cortisone are well known in various conditions and I will not take the time to elaborate on them here. However, there are a few points that deserve special consideration. The observations with these materials have emphasized two important things:

1. The important role of the adrenal cortex in body metabolism.

2. The importance of thinking of all diseases in terms of the body as a whole, e. g., the joint changes in patients with rheumatoid arthritis are merely one manifestation of a generalized disease. The bronchial spasm in patients with allergic asthma is merely one manifestation of a chemical alteration which involves the whole body, and it is hoped that the time will soon come when the allergist will be able to attack the causes of various allergic phenomena rather than give palliative therapy.

The observations with ACTH and cortisone have focused attention on the role of the adrenal cortex in the resistance of the body to stress and strain and to the various infections processes. The mechanism involved is not clearly understood but there appears to be no doubt about the importance of the adrenal cortex.

In patients with a fever, regardless of the cause, the administration of ACTH will cause the temperature to drop to normal. In pneumonia it causes the fever to disappear and produces marked subjective improvement, in spite of the fact that pneumococci continue to be produced and may even be present in the blood stream. In tuberculosis ACTH will cause the temperature to drop to normal, produce a sense of well-being, and cause a diminution of the x-ray evidence of the disease, in spite of the fact that tubercle bacilli continue to be produced. When its administration is discontinued, a severe exacerbation sets in.

John Browne has recently pointed out the important role which he considers the adrenal cortex plays in all disease states, and feels that our conception of the nature of disease must be modified. While the important role of the adrenal cortex cannot be doubted, it seems to me that we should proceed cautiously and draw only those conclusions that are warranted by the facts available. There is no doubt that out of the work with ACTH and cortisone important new concepts will develop.

*Dr Robert W. Keeton, Professor of Medicine*: You have stated that thyrotoxicisis might be inhibited by continued administration of thyrotropic hormone. Do you believe that this might

be due to a "burning out" of the thyroid gland by overstimulation?

*Dr. Thompson*: No, we feel that this inhibition is the result of an immunologic reaction. The molecule containing the hormone is rather complex and may stimulate the formation of specific antibodies.

*Dr. Max Samter, Assistant Professor of Medicine*: If the body responds to the injection of thyrotropic hormone with the formation of specific antibodies, one should expect similar response to the administration of ACTH. In our own experience, such an effect appears to be rather uncommon.

*Dr. Thompson*: Recent reports seem to indicate that immunity to ACTH does occur if the hormone is given over long periods.

*Dr. Harry A. Waisman, Research Associate in Pediatrics*: Have you used thyrotropic hormone derived from other animal species after immunity has developed to the one originally used?

*Dr. Thompson*: No, but we believe that it ought to be done. The fact that this "immunity" cures a pre-existing hyperthyroidism makes me believe, however, that it is not a species specific immunologic reaction.

*Dr Robert M. Kark, Professor of Medicine*: Adrenal tumors have been known to show feminizing effects, masculinizing effects and effects attributable primarily to glucogenic corticoids. I should like to know whether there has ever been a tumor of the adrenal whose only manifestations have been increased production of salt regulating hormones.

*Dr. Thompson*: The development of such a tumor is theoretically possible but I do not know of any that has been reported.

*Dr. Robert L. Grissom, Associate in Medicine*: Could you elaborate somewhat on the management of malignant exophthalmos?

*Dr. Thompson*: I had not planned to discuss therapy in detail. As a matter of fact, the treatment of exophthalmos is often very unsatisfactory. From the literature, one might be led to believe that thyroidectomy should increase exophthalmos because the pituitary might respond with increased activitiy; actually, in my experience, most patients show a reduction subjectively in their exophthalmos following a thyroidectomy. In the treatment of malignant exophthalmos the most conservative approach is the combined administration of desiccated thyroid and iodine. A decompression operation has to be resorted to only rarely.

*Dr. Alfred Leimdorfer, Research Professor in Pharmacology and Therapeutics, Stritch School of Medicine, Loyola University*: Do you believe that diabetes resulting from the administration of ACTH is permanent?

*Dr. Thompson*: Permanent diabetes is said to be one of the dangers of prolonged ACTH administration. It seems quite possible that this might develop only in patients who are potential diabetics. As a matter of fact, George Thorn has proposed this "test" as a method of detecting potential diabetics.

*Dr. Keeton*: This possibility seems very likely. Among those patients who were given ACTH at this hospital, only one has developed glycosuria. It has been shown that diabetics will become worse on ACTH. We look upon diabetes as a condition related to stress and exhaustion of the islet cells. This exhaustion can be the result of a variety of stresses. We might outline briefly our attempts to make a patient with a long standing hypo-insulinism diabetic. On 100 mgs. of Armour's ACTH daily, no effect was apparent on the low blood sugar. On 200 mgs. daily, the blood sugar approached normal and on 400 mgs. a day for two days, there was a transitory diabetic glucose tolerance test. We have not seen consistent alterations in the test following ACTH.

# Physical Medicine and Rehabilitation in the Veterans Administration*

**Louis B. Newman, M.E., M.D.**
Chief, Physical Medicine and Rehabilitation Service
Veterans Administration Hospital
**Hines**

At the present time, there are approximately 104,000 veterans hospitalized in the 128 Veterans Hospitals in the United States. The total medical care program for the Veterans Administration is under the direction of Dr. Paul B. Magnuson, Chief Medical Director, Central Office, Washington, D. C. Dr. A. B. C. Knudson is Chief of the Physical Medicine Rehabilitation Division, Central Office. In addition to the already existing number of disabled veterans, 265,000 men were permanently disabled during World War II. It has been reliably estimated that the number of hospitalized veterans will be on the increase and that the maximum load will be about the year 1975. The job of rehabilitating these veterans, therefore, has only begun.

The Physical Medicine and Rehabilitation Service, which is directed by the physiatrist, who is chief of the service, consists of the following sections: Physical Therapy, Occupational Therapy, Corrective Therapy, Educational Therapy, Manual Arts Therapy and a Central Rehabilitation Section for the Blind at the Veterans Administration Hospital, Hines, Illinois. Oral rehabilitation is available through some of the Veterans Administration Regional Offices throughout the country.

The Central Rehabilitation Section for the Blind was established on May 20, 1948, at the Veterans Administration Hospital, Hines, Illinois. The function of this program is to provide an opportunity for the blinded veteran to become familiar with mechanical and other aids used to solve problems of blindness; to acquire basic skills in the use of special apparatus; to come into contact with blinded individuals who meet a high performance without sight and to have an opportunity to plan an individualized program with knowledge of all resources available in this country. This includes personal and social adjustment and reorganization as well as conversion of common skills to performance without sight.

There are seven Centers for veterans with spinal cord injuries, located at Hines, Van Nuys (California), Bronx (New York), Memphis (Tennessee), Framingham (Massachusetts) and Staten Island (New York); the one at Hines being the largest, where there are always 300 patients with this type of injury receiving medical care.

A Tuberculosis Rehabilitation Center has been established at the Swannanoa Division of the Oteen Veterans Administration Hospital, North Carolina, where a complete rehabilitation program has been developed for tuberculous patients. This special rehabilitation treatment which is given at this center, is a part of the regular medical care which each patient receives there. The program helps these patients to overcome the handicap of tuberculosis and bridge the gap between the hospital bed and the work-a-day world. There are 17 other Veterans Administration Tuberculosis Hospitals in various sections of the country having rehabilitation programs.

At Fort Thomas, Kentucky, the Veterans Administration has established a medical rehabilitation hospital to further aid in returning the disabled veteran to an active and useful life. Physical medicine and rehabilitation is available at all Veterans Administration Hospitals.

The goal of physical medicine and rehabilitation in the Veterans Administration is the restoration of the disabled veteran to as full a life as possible. Merely an existance or the pro-

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**Read at the Session on Physical Medicine and Rehabilitation at the Annual Session of the American Medical Association, Atlantic City, New Jersey, June 8, 1949.**

longation of life is not sufficient. To secure for these veterans a measure of happiness, contentment and satisfaction is paramount. It is the desire and hope to return these individuals to their respective communities as useful citizens, inculcated with the feeling that there is a definite place for them in this world. As has been very aptly stated, we must give "life to years."

By means of physical medicine and rehabilitation, the objective of maximum restoration is attained; however, the degree of success depends upon the following: an interested and cooperative patient; the type and extent of the disability; a complete and careful evaluation of the disability; prompt institution of the prescribed indicated rehabilitation procedures for a sufficient period of time, by qualified personnel.

Motivation and stimulation of the patients in order to secure maximum cooperation is vital. An interested patient is usually a cooperative one. It is our duty to stimulate interest and to arouse enthusiasm in the patient toward his recovery and well-being. The patient must believe and have faith in you and your planned program.

The amount of recovery that can be secured is usually related to the type and extent of the disability. It is readily appreciated that with a serious disability, the veteran will usually present many more difficult problems in rehabilitation than one who is suffering from a minor disability. One having a mental illness or a spinal cord injury, with its associated complications, or one who has lost his sight, or has lost an arm or leg or his hearing, is usually a problem of greater significance than one having a minor disability such as a simple fracture of the fibula.

A most complete and careful evaluation of the disability before instituting treatment is fundamental. In physical medicine and rehabilitation rarely does an emergency exist necessitating immediate treatment. Therefore, time should be taken in order to make a very careful study of the total individual in so far as function and usefulness is concerned; range of motion and muscle strength should be carefully measured and recorded; coordinated movements should be studied. Evaluation of the disability must be done as scientifically as possible so that a true picture will be had. Upon completion of the evaluation, a concise, detailed prescription for the necessary physical medicine and rehabilitation procedures should be prepared. Frequent periodic reevaluations should be done in order to properly determine the value of the instituted treatments and also the patient's progress.

The promptness that rehabilitation is instituted cannot be over-emphasized. Rehabilitation procedures must be started early in order to secure maximum results with the least amount of residual handicap. Treatment should be started while the patient is still confined to bed, if his general condition warrants. The time elapsed between the onset of the disability and the institution of physical medicine and rehabilitation must be a minimum.

Indicated prescribed treatment must be carried on for a sufficient length of time. A common error is to discontinue treatment before maximum results have been accomplished. Many individuals would have been left with a much lesser degree of disability and resulting handicap, if treatment had been carried on for a longer period of time. To resume treatments that have been discontinued during the critical stage of rehabilitation may not remedy the harm that has already been done by not persisting in continued treatment. Equally as important is having treatments instituted by qualified personnel.

Complete integration of all activities and services, such as: Medical, Physical Medicine and Rehabilitation, Psychiatric, Nursing, Social Service, Vocational Advisement, etc., into a closely organized team with the physiatrist in charge is paramount. In order to further direct every available service toward the maximum rehabilitation of each patient, a Rehabilitation Board has been established, with the Chief of the Physical Medicine and Rehabilitation Service as Chairman. The function of this board is to plan, initiate and evaluate periodically a specific rehabilitation program for the veteran; to guide and advise the patient throughout his period of hospitalization; to assure that the maximum benefits of all services are brought to bear upon the individual patient's case in achieving his rehabilitation; to coordinate the rehabilitation program in the hospital with the post-hospital plans of the veteran. Social and psychological preparation and adjustment, including vocational guidance and placement is of extreme importance.

Those veterans with disabilities such as spinal

(*Continued on page* 153)

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

# Case of Chest Trauma

**William Klingensmith, M.D.**
Resident in Surgery
**and Ralph Ryan, M.D.**
Interne on the Surgical Service

J. S., a 25-year old colored man, was admitted to the Cook County Hospital on April 1, 1950 with a history of having been stabbed in the chest with a butcher knife two hours previously. He had no specific complaints on admission except "a catch in the right side of the chest". He had always been in excellent health and a complete history elicited no other symptoms. He did not complain of shortness of breath, cough, hemoptysis or pain on breathing.

On physical examination, he was found to be well-developed and well-nourished. The blood pressure was 120/80, pulse 80, respirations 22, and temperature 99°F. There were small, superficial lacerations over the lateral aspect of the right chest and in the left axilla. There was a three centimeter laceration to the right of the sternum in the third interspace that was sucking air with each respiration. Expansion of the right chest was limited and breath sounds were decreased throughout. There were no changes in percussion. The heart tones were normal and there was no shift of the heart to the left. The remainder of the physical examination was entirely negative, and routine blood and urine studies were normal.

The clinical impression at the time of admission was a sucking stab wound of the right chest with pneumothorax. The chest was washed with soap and water and the sucking wound was immediately closed with interrupted black silk sutures and covered with vaseline gauze and a pressure dressing. Three hundred thousand units of penicillin in oil and wax and three thousand units of tetanus antitoxin were given and an emergency chest plate was ordered (Figure 1). This plate showed a partial collapse of the right lung with air in the pleural space and fluid in the costo-phrenic angle. A large calcified node was noted in the right hilum. Immediate thoracentesis was done; 300 cc of air and 75 cc of blood was obtained from the eighth interspace posteriorly. The patient continued to feel well and was able to lie flat in bed and sleep all night without difficulty.



Figure 1: Chest plate made soon after admission. Note the partial collapse of the right lung with obliteration of the costo-phrenic angle by fluid and the old calcified gland in the hilum.



Figure 2: Chest plate made the day after admission. Note the complete collapse of the lung by the air in the pleural space. A fluid level is also seen. Patient had no dyspnea or other complaints at this time.

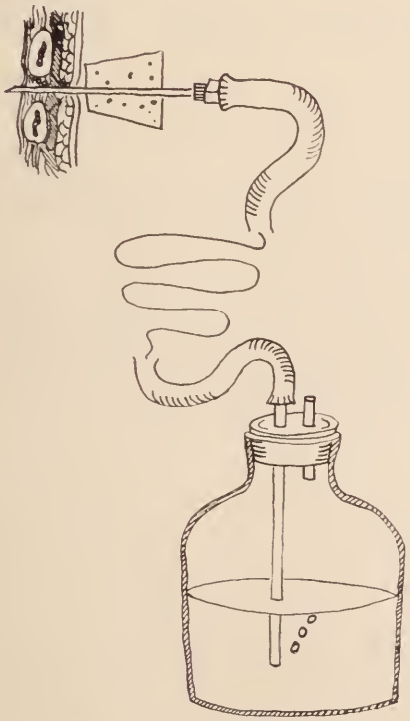


Figure 3: Diagram of water seal drainage with needle in the pleural space. Needle is held in place by cork taped to the chest wall. Water seal prevents air from re-entering the pleural space as it is forced out by the expanding lung. Bottle must not be raised to chest level or water will enter chest.

The next morning it was noticed that breath sounds were completely absent throughout the right chest and that the chest was hyper-resonant to percussion. A diagnosis of pneumothorax was again made, and an immediate chest plate was obtained (Figure 2). This showed a massive collapse of the right lung with some fluid in the costo-phrenic angle. Because of the recurrent extensive pneumothorax, water seal drainage was instituted (Figure 3). A number sixteen needle was introduced into the pleural cavity through the third interspace anteriorly and connected by sterile rubber tubing to a sterile water-seal bottle on the floor. The needle was introduced through a cork, and this was taped to the chest and covered with a dressing. The patient was encouraged to breath deeply and to blow out the cheeks with air as forcibly as possible, and large amounts of air were expelled beneath the water. This drainage was left in place for five hours with the patient semi-erect in bed. It was then removed because of the danger of the needle puncturing the expanding lung. At the time of removal the chest was clear to percussion and auscultation. A chest plate (Figure 4) made the next morn-

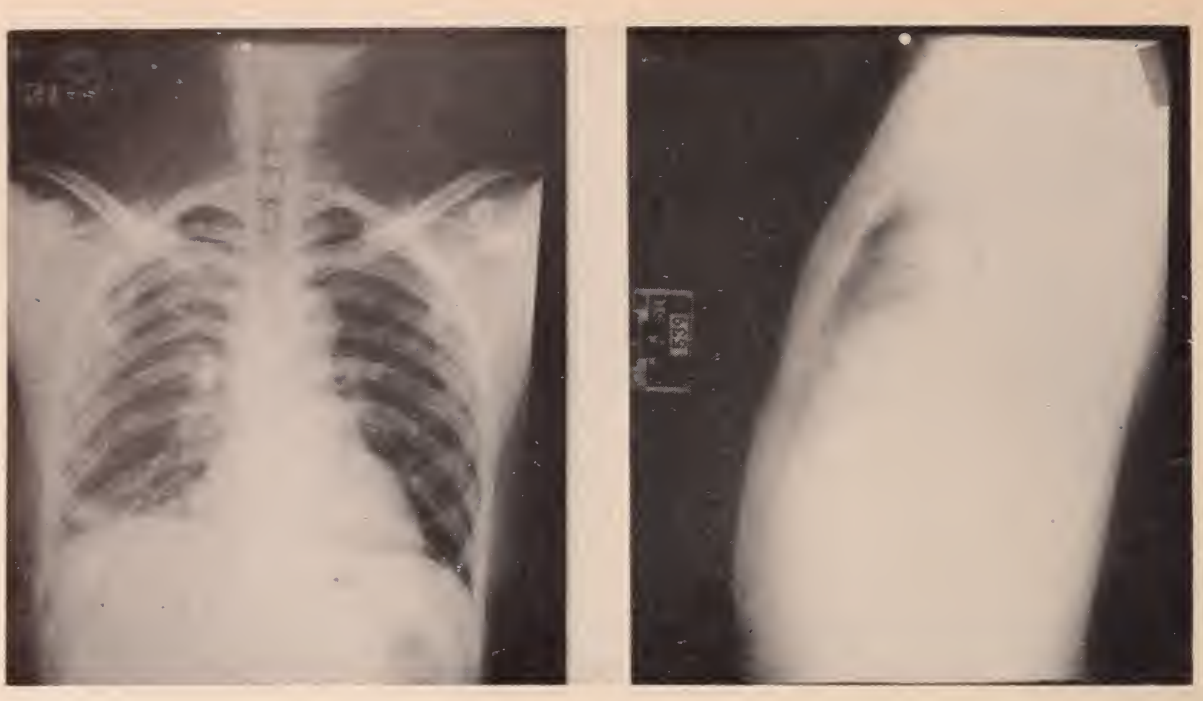


**Figure 4a and 4b: Chest plates made after water seal drainage had been employed for five hours. Lung completely expanded in AP and lateral views.**

ing showed an essentially normal chest and the patient was discharged after one more day of observation in the hospital on the fourth hospital day. When seen one week later, he was symptom-free and the chest was clear.

COMMENT

This patient's physical findings and films illustrate the condition of stab-wound of the chest wall and lung with hemo-pneumothorax and its response to early aspiration and water-seal drainage. The use of a needle in the pleural space in not without danger of puncturing the expanding lung and for that reason must be watched closely and removed early. The introduction of a colon tube laterally through a thoracostomy wound and institution of water seal drainage is more useful for longer periods of drainage.

The sucking wound of the chest wall was closed immediately and additionally sealed with vaseline gauze. The foreign material in the chest was aspirated at once; it is most important that blood be removed early and completely. The danger of further bleeding from the lung is slight because of the low blood pressure in the pulmonary circuit. Early aspiration is now practiced on most of the wards of the Cook County Hospital.

It is of interest to note that this patient had no symptoms of respiratory embarrassment despite the complete collapse of the right lung on the second hospital day.

# CASE REPORTS



# Cardiac Aneurysm Demonstrated by Angiocardiography

**Erwin Kammerling, M.D., John B. Cavenagh, M.D., and Leon Unger, M.D., F.A.C.P.**
**Chicago**

The differential diagnosis of aneurysms and mediastinal tumors has become more important because of the recent advances in surgery of the mediastinum. This differentiation is not always possible by routine clinical and roentgen methods. The following case is presented to emphasize the value of angiocardiography in the differential diagnosis of a mediastinal mass after ordinary clinical and roentgenoscopic methods had failed.

E. H., 27, Negro housewife, was admitted to Cook County Hospital November 12, 1948 with palpitation, nausea and vomiting of one week duration, with onset during a menstrual period. This was her fourth hospital admission.

*First admission*: In February, 1946, the patient entered because of anorexia, malaise, weakness, weight loss, and a draining sinus in the right supraclavicular area of seven months duration. Biopsy of a cervical node at this time revealed fibrocaseous tuberculosis. Her blood pressure was 128 mm. Hg systolic and 86 mm. diastolic. *X-ray of the chest revealed normal heart and lungs.* The patient responded to bed rest and symptomatic therapy and was discharged six weeks after admission.

*Second admission*: In October, 1946, she reentered the hospital with complaints of palpitation and vomiting, the onset having occurred at the time of her menses two days previously. (A similar, less severe episode had occurred three months previously.) Physical examination revealed a poorly developed, poorly nourished female, 25 years of age, who was dyspneic and acutely ill. Her blood pressure was 104 mm. Hg systolic and 88 mm. diastolic, temperature 97.6, apical heart rate 192 with pulse 96 and respiration 36. The cardiac apex extended to the mid-

**From the Department of Medicine, Cook County Hospital, Chicago, Illinois, Service of Leon Unger, M.D.**

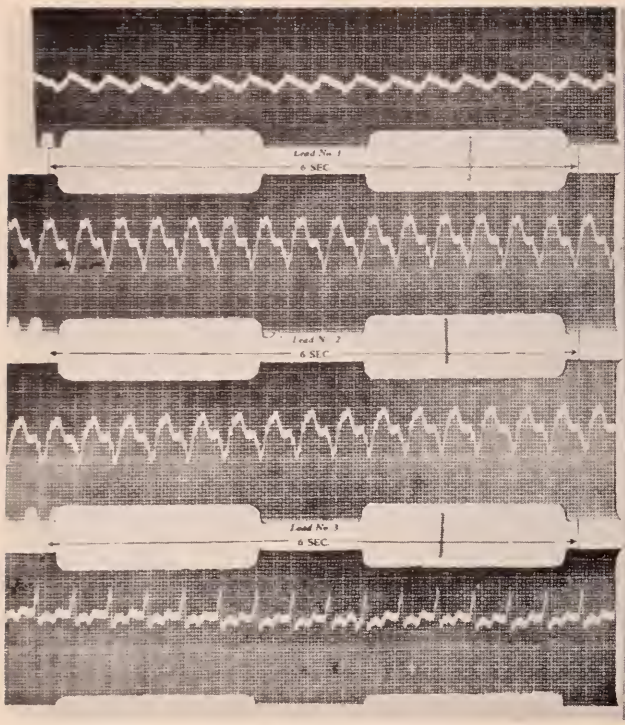



**Figure 1. Electrocardiogram October 5, 1946 — Paroxysmal ventricular tachycardia.**

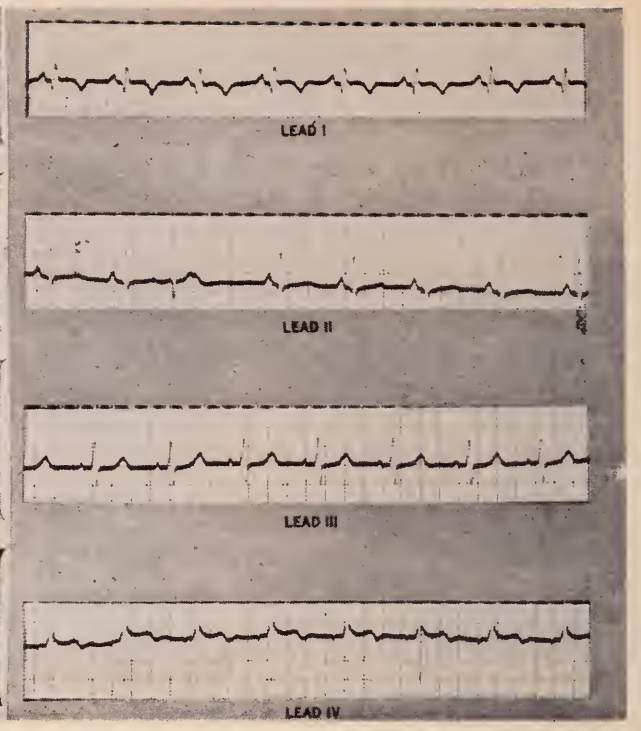



**Figure 2. Electrocardiogram November 4, 1946 — Note changes from Figure 1.**

axillary line and a pericardial friction rub was heard. Electrocardiogram revealed a paroxysmal ventricular tachycardia (Figure 1). She was treated with intravenous quinidine (having vomited the oral medication), oxygen, morphine and atropine. As the cardiac rhythm returned to normal, the pericardial friction rub disappeared. The patient was asymptomatic one and one-half weeks after admission and insisted upon leaving the hospital. Diagnoses at the time of her discharge were:

(1) Paroxysmal ventricular tachycardia
(2) Also to be considered:
    (a) Tuberculous pericarditis
    (b) Anterior myocardial infarction

*Third admission*: She returned to the hospital one week later with nausea, epigastric discomfort, tightness in the chest, and palpitation. She was dyspneic and acutely ill. Her blood pressure was 98 mm. Hg systolic and 72 mm. diastolic, pulse 180, temperature 97 and respiration 26. Examination of the heart disclosed a diffuse apex beat extending to the anterior axillary line. The right heart border was at the right parasternal line. No murmurs or friction rub were heard. X-ray and fluoroscopy of the chest confirmed the physical findings; the aorta was small. Quinidine was given orally and the cardiac rhythm returned to normal within three days. Serial electrocardiograms were taken. An electrocardiogram on this admission again revealed a paroxysmal ventricular tachycardia. Two weeks later, the electrocardiogram changed and now revealed (Figure 2):

Lead I: P upright, notched — Q present, ST slightly elevated with T inverted.
Lead III: ST slightly depressed with T upright.
Lead IV: ST elevated with T diphasic to inverted.

The patient remained afebrile and became asymptomatic; she was discharged one month after admission.

During the following two years there were several episodes of palpitation, mild nausea and occasional vomiting which usually occurred with the onset of her menses. Between these attacks, she considered herself to be in good health.

*Latest (fourth) admission (November* 12, 1948): Physical examination revealed a slender, fairly-well nourished female who appeared chronically ill. Her blood pressure was 105 mm. Hg systolic and 80 mm. diastolic, pulse 100, temperature 97.6 and respiration 24. Essential

physical findings were: normal fundi, slight distention of the neck veins in the upright position, and enlargement of the liver three fingers below the right costal margin, smooth and nontender. There was no peripheral edema. There was a forceful cardiac impulse in the fourth to sixth left intercostal spaces extending to the posterior axillary line. There was also a visible heaving of the anterior chest wall with each contraction of the heart, the right side of the chest appearing to lag slightly behind the left side. On percussion, the area of right cardiac dullness was 2 cm. to the right of the right parasternal line. There was no widening at the base or in the third left intercostal space. No murmurs or friction rub were heard. The second aortic tone was louder than the second pulmonic.

The first x-ray of the chest revealed a "circular opacity adjacent to or continuous with the left side of the heart. The diaphragms appeared in normal position." On subsequent examination and fluoroscopy by several of the attending and resident staff, opinion was divided as to whether the density was part of the left ventricle or a separate mass adherent to the ventricle and transmitting the cardiac pulsation. The electrocardiogram (Figure 3) revealed a paroxysmal ventricular tachycardia. This rhythm converted spontaneously to a sinus mechanism within two days. The tachycardia recurred one week after admission and converted to a sinus mechanism with quinidine (Figure 4). The chest surgical service examined the patient and made the following diagnosis: "a tumor of the left lower chest with pressure on the pericardial sac and contents; suspect pericardial cyst, fibroma, etc." Surgical exploration was advised.

*Laboratory Data*: Routine laboratory studies, including urinalysis, blood counts and differential and blood Kahn were not contributory. A muscle biopsy revealed no evidence of periarteritis nodosa. Serial electrocardiograms revealed alternately: (1) paroxysmal ventricular tachycardia and (2) sinus rhythm with evidence of previous anterolateral myocardial infarction. Electrocardiograms just prior to and following angiocardiography revealed a sinus mechanism.

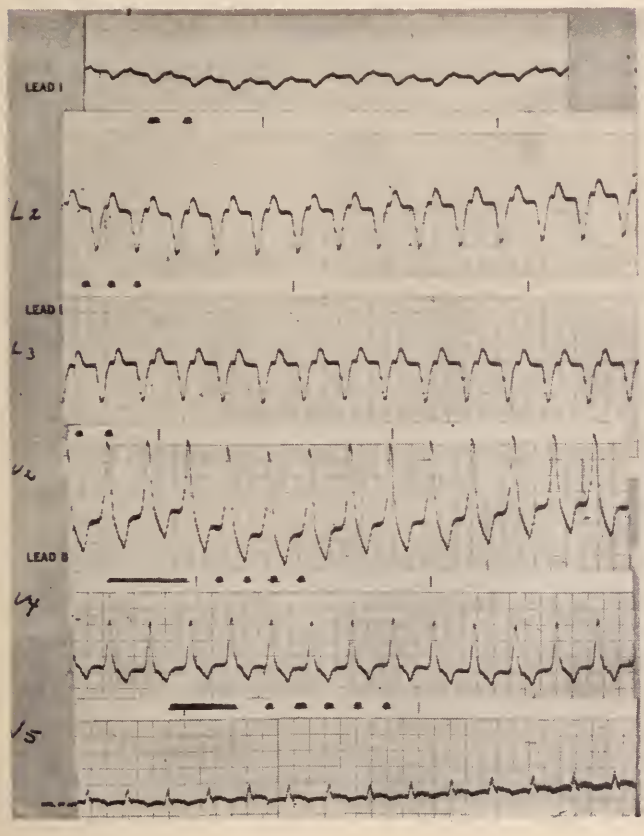



**Figure 3. Electrocardiogram November 13, 1948 — Note great similarity with tracings in Figure 1.**

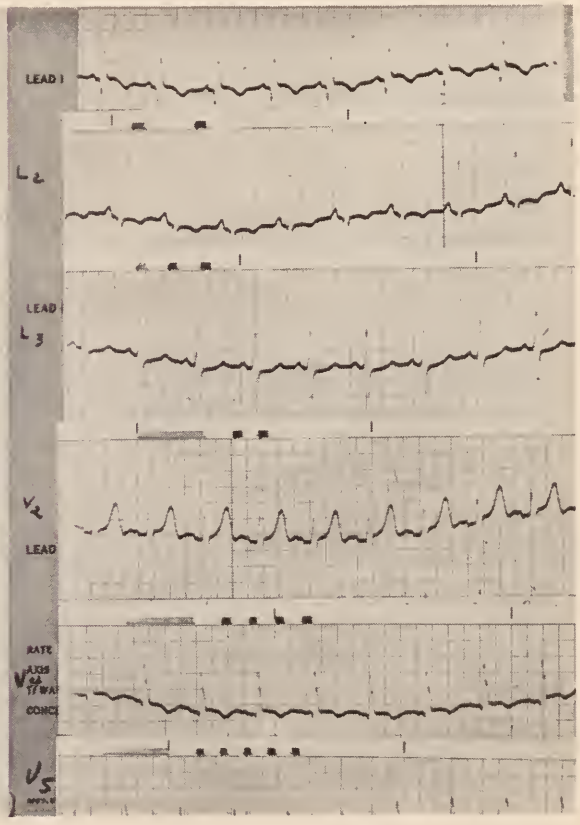



**Figure 4. Electrocardiogram December 9, 1948 — Sinus mechanism with evidence of previous anterolateral myocardial infarction.**



**Figure 5. Chest x-ray film just prior to the intravenous injection of the dye. Note the unusual and marked density which cannot be distinguished from the heart itself.**

**Figure 6. Chest x-ray film taken a few seconds after intravenous injection of the Diodrast. Note the aneurysm of the left ventricle, almost completely filled with the dye.**

*Angiocardiography*:* Skin and ocular tests did not reveal sensitivity of the patient to 70% Diodrast. Circulation time with sodium cyanide was 14.2 seconds. Fifty cc. of Diodrast was rapidly injected into the right antecubital vein without untoward reaction. The levo-angiocardiogram revealed a greatly dilated left ventricular cavity with dye filling most of the area under question. The aorta was normal. Figure 5 is the chest film prior to injection of the dye. Figure 6 reveals the ventricular aneurysm filled with the Diodrast.

The patient was discharged on 0.2 Gm. quinidine four times a day and twelve weeks later had no complaints. Electrocardiogram fifteen months later revealed sinus rhythm.

*Comment*: The finding of a large mass adjacent to or continuous with the left ventricle in a 27 year old Negress with recurrent paroxysmal ventricular tachycardia evoked a great deal of interest as a diagnostic problem, especially in the absence of a history suggestive of coronary thrombosis or of trauma to the chest. The patient was examined by many of the attending and resident staff, with fluoroscopy by several. Prior to angiocardiography, opinion was divided between the diagnosis of ventricular aneurysm, pericardial cyst, or extracardiac neoplasm invading the heart or pericardium. Because of the finding of tuberculous adenitis on her first admission, the diagnosis of tuberculous pericarditis was also considered. The levo-angiocardiogram, which revealed the greatly dilated left ventricular cavity with dye filling most of the area under question, conclusively established the diagnosis of ventricular aneurysm.

*Angiocardiography was performed by a team composed of Drs. G. C. Sutton, G. Wendel, H. Grant and H. G. Wedell of the Preble Laboratory of Cook County Hospital. The Diodrast was furnished by Winthrop-Stearns, Inc.

## SUMMARY

1. The diagnosis of aneurysm of the left ventricle was proven, for the first time to our knowledge, by angiocardiography.

2. This case emphasizes the value of angiocardiography in the differential diagnosis of aneurysms and mediastinal masses after ordinary clinical and roentgenoscopic methods have failed.

3. In this patient there is the coincidental occurrence of three unusual cardiac abnormalities: myocardial infarction in a young female with neither diabetes nor hypertension, a subsequent recurrent paroxysmal ventricular tachycardia, and aneurysm of the left ventricle.

109 North Wabash Avenue

# HOUSE OF DELEGATES



The second session of the House of Delegates was called to order by the President, Dr. Walter Stevenson on Thursday, May 25, 1950 at 9:25 A.M.

THE PRESIDENT: The next order of business will be the roll call by the Secretary. (The Secretary called the roll of Delegates.)

THE PRESIDENT: The next order of business will be the report of the Credentials Committee by Dr. E. S. Hamilton.

DR. E. S. HAMILTON, Kankakee: The Credentials Committee has certified 128 delegates, 5 officers and 15 members of the Council, a total of 148. I move you Mr. President that this constitute the voting strength of the House for this session. (Motion seconded by Dr. Mather Pfeiffenberger and carried).

THE PRESIDENT: The next order of business is the approval of the Minutes of the previous session.

DR. G. HENRY MUNDT, Chicago: I move that the reading of the Minutes be dispensed with. (Motion seconded by Dr. Warren Furey, Chicago, and carried).

THE PRESIDENT: The next order of business will be the announcement of awards to scientific exhibitors by the Chairman and Director of the Scientific Exhibits, Dr. Coye C. Mason.

Dr. Mason gave the following report: —

**Educational Value**

Gold Medal: Louis River, Joseph Silverstein, Hektoen Institute, Cook County Hospital, Stritch Medical School of Loyola University and the Doctor Jerome D. Solomon Memorial Research Foundation.

"Carcinoma of the Breast: Diagnosis and Selection of Treatment."

Silver Medal: Warren H. Cole, William Requarth, Gloria Kenney. University of Illinois College of Medicine. "Appendicitis".

Bronze Medal: Peter C. Kronfeld, Glen Ford, Illinois Eye and Ear Infirmary of the University of Illinois.

"Steroscopic Kodachrome Transparencies of Diseases of the Fundus Oculi".

Bronze Medal: Carroll L. Birch, Louis R. Limarzi, P. L. Bedinger, Raymond S. Kibler. University of Illinois College of Medicine.

"Multiple Myeloma".

Bronze Medal: James Graham, Arthur Lindsay, James Cunningham Springfield Clinic.

"Carcinoma of the Colon and Rectum".

**Original Work**

Gold Medal: Lester R. Dragstedt, Edward R. Woodward, Edward H. Storer, Harry A. Oberhelman, Jr. Curtis A. Smith, Department of Surgery, University of Chicago

"Quantitative Studies on the Mechanisms of Gastric Secretion."

Silver Medal: Lewis J. Pollock, Benjamin Boshes, Herman Chor, Isidore Finkelman, Meyer Brown, Alex J. Arieff, Joseph G. Kostubala, Louis B. Newman. U. S. Veterans Administration Hospital, Northwestern University Medical School.

"Management of Injuries to Spinal Cord and Cauda Equina."

Bronze Medal: Linden J. Walner, George C. Turner, Meyer Lichtenstein, and Henry C. Sweany. Municipal Tuberculosis Sanitarium, Veterans' Hospital, Hines, University of Illinois.

"Treatment of Tuberculous Laryngitis by Chemotherapy."

Bronze Medal: D. E. Clark, O. H. Trippel, G. E. Sheline, M. C. Moore. University of Chicago.

"Radioactive Iodine: Its Use in Diagnosis and Therapy."

Bronze Medal: Harold C. Voris, Stritch School of Medicine, Loyola University.

"Treatment of Intracranial Aneurysm".

THE PRESIDENT: I would like to say to you, when I first came here I went down to the exhibit hall and saw a fellow in overalls and with no shirt putting up the exhibit. I asked him if he could tell me where I could find Dr. Mason and he said, "I am Mason." Dr. Mason has done an enormous amount of work on the scientific exhibit. We have more scientific exhibits than in Chicago and he certainly deserves the thanks of all of us. (Applause).

THE PRESIDENT: We come to a very important part of the agenda, that is the election of officers. The first nomination will be for President-Elect.

DR. GEORGE E. KIRBY, Spring Valley: It gives me very great pleasure at this time to place in nomination for President Elect a member of the Henry County Medical Society, Dr. C. Paul White of Kewanee. (Motion seconded by Dr. E. H. Weld, Rockford).

DR. E. H. WELD, Rockford: I move that the nominations be closed and that the Secretary cast the affirmative ballot for Dr. White (Motion seconded by Dr. L. J. Hughes, Elgin and carried). (The ballot was cast and the President declared Dr. White elected.)

DR. C. PAUL WHITE: Mr. President and members of the House of Delegates: I assure you that this is an honor which you have conferred upon me that I certainly do not take lightly. It is a great honor but at the same time it is a tremendous responsibility, not only a responsibility for me but it is a responsibility that you have taken upon yourselves for the next two or three years. I am not unmindful of the fact that next year I am simply the right or left hand bower to President Harry Hedge. I shall endeavor to support him and do his bidding as well as that of the Council and as well as that of you, our delegates. However, I trust that I shall not be a rubber stamp but rather a postage stamp on the road to success because the motto of the postage stamp is that it sticks to one thing and it gets it done. With all of these questions that are coming up pro and con for the profession we must think right, but gentlemen, we can not think right unless you go back to your component societies and you get them to think right and to act. Whatever I will be able to do in the next year and the following year as President will only be done when I know that I have the support of each and every member of the Illinois State Medical Society. We can accomplish a lot if we will all work. The opportunity is large. I remind you that the door of opportunity is there and all you have to do is to push it open but this means that you must push. Gentlemen I thank you. I thank you for this honor and I trust I will be worthy of it.

THE PRESIDENT: Thank you Paul. Nominations are now in order for First Vice-President.

DR. E. S. HAMILTON, Kankakee: It would give me great pleasure to present in nomination the name of Dr. Jacob Reisch of Springfield.

DR. OSCAR HAWKINSON, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Jacob Reisch as First Vice-President. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried). (The ballot was cast and the President declared Dr. Reisch elected.)

DR. REISCH: Thank you Dr. Stevenson. Thank you all for this honor which you have conferred not only upon myself but upon the Sangamon County Medical Society. I want to say at this time that Sangamon County is indeed honored to have been the host county of the State Medical Society. Experience is a great teacher and I think that future conventions could be made better in this city. I want you to know that the Sangamon County Medical Society is alert to the problems facing medicine today. We are going to make every effort possible to carry out the work that our President and past Presidents have started. Welcome to Springfield, I hope you stay long here.

THE PRESIDENT: Nominations are in order for Second Vice-President.

DR. W. O. THOMPSON, Chicago: Mr. President, the Chicago caucus was held Tuesday afternoon after the meeting of the House of Delegates. At this caucus certain candidates were decided upon. I should like to recommend that Dr. Scatliff who was the Secretary of the caucus and who is at present the Secretary of the Chicago Medical Society, be allowed to present these candidates to the House of Delegates when the various positions come up.

THE PRESIDENT: If there is no objection to that on the part of the Chicago Delegation we will follow that plan.

DR. H. K. SCATLIFF, Chicago: The wish of the caucus as mentioned by Dr. Thompson recommends that you consider the name of Dr. Anthony J. Linowiecki, Chicago, who is a hard working member of the Northwest Branch and who will be an addition to any group of officers. I place in nomination the name of Dr. A. J. Linowiecki for Second Vice-President. (Motion seconded by Dr. James H. Hutton, Chicago and carried).

DR. OSCAR HAWKINSON, Oak Park: I move that the nominations be closed and that the Secretary cast the affirmative ballot for Dr. Linowiecki. (Motion seconded by Dr. Robert Hayes, Chicago. and carried).

(The ballot was cast and the President declared Dr. Linowiecki elected).

THE PRESIDENT: The nominations are in order for Secretary-Treasurer.

DR. E. E. DAVIS, Avon: I wish to place in

nomination the name of Dr. Harold M. Camp to succeed himself. (Motion seconded by Dr. F. L. Stone, Chicago, and carried).

DR. E. H. WELD, Rockford: I move that the nominations be closed and the President cast the affirmative ballot for Dr. Camp. (Motion seconded by Dr. Robert Hayes, Chicago, and carried).

THE PRESIDENT: I take pleasure in casting the unanimous ballot for Dr. Harold M. Camp.

The next order of business will be the election of Councilors, Dr. L. J. Hughes, Elgin, retiring as Councilor of the 1st District.

DR. L. S. GREENWOOD, Rockford: I would like to place in nomination the name of Dr. Joseph Lundholm, Rockford. (Seconded by Dr. E. H. Weld, Rockford).

DR. E. E. DAVIS, Avon: I move that the nominations be closed and that the Secretary cast the affirmative ballot for Dr. Joseph Lundholm as Councilor of the 1st District.

(Motion seconded by Dr. L. S. Greenwood, Rockford and carried). The ballot was cast and the President declared Dr. Lundholm elected as Councilor of the 1st District.)

THE PRESIDENT: Nominations are in order for Councilor of the 2nd District, the term of Dr. Joseph T. O'Neill, Ottawa, expiring.

DR. J. H. EDGCOMB, Ottawa: I wish to place in nomination the name of Dr. Joseph T. O'Neill to succeed himself. (Motion seconded by Dr. W. E. Kittler, Rochelle.)

DR. J. H. EDGCOMB: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Joseph T. O'Neill. (Motion seconded by Dr. E. E. Davis, Avon and carried.) (The ballot is cast and the President declared Dr. Joseph T. O'Neill re-elected as Councilor of the 2nd District.)

THE PRESIDENT: Nominations are in order for Councilors of the 3rd District, the terms of Drs. F. Lee Stone and Wade C. Harker expiring.

DR. H. K. SCATLIFF, Chicago: I would like to place in nomination the names of Drs. Leo P. Sweeney in place of Dr. Walter Bornemeier who has resigned from the Council, F. L. Stone and Wade C. Harker. (Seconded by Dr. W. O. Thompson, Chicago.)

DR. WALTER BORNEMIER, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Drs. Leo P. Sweeney, F. L. Stone and Wade Harker. (Motion seconded by Dr. Robert Hayes, Chicago and carried.) The ballot was cast and the President declared Drs. Leo P. Sweeney, F. L. Stone and Wade Harker elected as Councilors of the 3rd District.

THE PRESIDENT: Nominations are in order for Councilor of the 11th District, the term of Dr. Edwin S. Hamilton, Kankakee, expiring.

DR. BERNARD J. KLEIN, Joliet: I wish to nominate Dr. E. S. Hamilton to succeed himself. (Seconded by Dr. E. H. Weld, Rockford).

DR. WARREN FUREY, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. E. S. Hamilton as Councilor of the 11th District. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried). (The ballot was cast and the President declared Dr. E. S. Hamilton re-elected as Councilor of the 11th District).

THE PRESIDENT: The next order of business is the election of Delegates to the American Medical Association, to take office on January 1st, 1951 and serve for a term of two years. The terms of the following expiring: Drs. G. Henry Mundt, Chicago, Rollo K. Packard, Chicago, Charles H. Phifer, Chicago, Bernard Klein, Joliet, Willis I. Lewis Herrin.

DR. H. K. SCATLIFF: I would like to place in nomination the names of Drs. Percy E. Hopkins, Warren W. Furey and Charles H. Phifer. (Seconded by Dr. Robert Hayes, Chicago).

DR. V. SERON, Joliet: I wish to place in nomination the names of Drs. Bernard Klein of Joliet and Willis I. Lewis of Herrin to succeed themselves.

DR. MATHER PFEIFFENBERGER: I move that the nominations be closed and the Secretary cast the affirmative ballot for Drs. Percy E. Hopkins, Warren W. Furey, Charles H. Phifer, Bernard Klein and W. I. Lewis. (Motion seconded by Dr. H. A. Felts, Marion and carried).

(The ballot was cast and the President declared the five candidates elected).

THE PRESIDENT: The next order of business is the election of Alternate Delegates to the American Medical Association to take office January 1st, 1951 and serve for a term of two years, the terms of the following expiring: Drs. Gustav Kaufman, Chicago, Warren W. Furey, Chicago, Karl L. Vehe, Chicago, James E. Wheeler, Belleville and K. B. Reiger, Freeport.

DR. H. K. SCATLIFF: I would like to place in nomination the names of Drs. W. O. Thompson, Karl L. Vehe and G. Henry Mundt to act as Alternate Delegates for the first three named as delegates to the American Medical Association.

DR. G. C. OTRICH, East St. Louis: I wish to place in nomination the name of Dr. J. E. Wheeler, Belleville to succeed himself.

DR. J. K. HANSON, Moline: I wish to place in nomination the name of Dr. David B. Freeman, Moline, to take the place of Dr. K. B. Reiger.

DR. H. K. SCATLIFF, Chicago: I move the nominations be closed and the Secretary cast the affirmative ballot for Drs. W. O. Thompson, Karl L. Vehe, G. Henry Mundt, J. E. Wheeler and David B. Freeman as Alternate delegates to the American Medical Association. (Motion seconded by Dr. G. C. Otrich, East St. Louis and carried).

(The ballot was cast and the President declared

the five candidates elected as Alternate Delegates to the American Medical Association.)

DR. JAMES H. HUTTON, Chicago: Mr. President and members of the House of Delegates: We have just witnessed a profound change in the complexion of our delegates to the American Medical Association. Dr. Mundt has been a member of that Delegation for more years than I know of. In this very city some 8 or 10 years ago Dr. Mundt said that there was a time when a man should retire and do it graciously. I think there is one thing to do here. I think we should give Dr. Mundt a rising vote of thanks for long and faithful service of 32 years.

DR. G. HENRY MUNDT: Mr. President and members of the House of Delegates: Now you can see what a fine group of fellows we have in Chicago. I think we are exceptionally fortunate in Chicago to have a group like this. These men who are going into the House of Delegates of the American Medical Association are tops. I think I can speak for the first one whom we nominated, Percy E. Hopkins. I have known Percy so long and so well that I yield to no one in his admiration. I have never known a man who has grown so beautifully as Percy. I am certainly pleased to have him in the House of Delegates. I am certainly pleased to have Warren Furey in the House because Warren always knows his way around. I am always pleased to see Charlie Phifer because no one pulls more punches than Charlie. I am indebted to this Association for so many nice things that I just had to say this and I rarely ask for opportunity to speak before a group like this.

THE PRESIDENT: The next order of business is the election of the Standing Committees; (a) Medico-Legal Committee, two members to be elected for a term of three years; the terms of Drs. Darwin B. Pond, Chicago and Ralph McReynolds, Quincy, expiring.

DR. H. K. SCATLIFF, Chicago: We would like to place in nomination for a member of the Medico-Legal Committee a man who has worked for some time in that capacity and who is exceptionally well qualified, Dr. Darwin B. Pond, Chicago.

DR. E. S. HAMILTON, Kankakee: I wish to nominate Ralph McReynolds, Quincy, to succeed himself.

DR. MATHER PFEIFFENBERGER: I move that the nominations be closed and the Secretary cast the ballot for Drs. Pond and McReynolds. (Motion seconded by Dr. J. H. Hutton, Chicago, and carried.)

(The ballot was cast and the Chair declared Drs. Darwin B. Pond, Chicago and Ralph McReynolds, Quincy, elected to the Medico-Legal Committee for a term of three years.

THE PRESIDENT: Nominations are in order for (b) Committee on Medical Education and Hospitals, one member to be elected for a term of three years; the term of Andrew C. Ivy, Chicago, expiring.

DR. H. K. SCATLIFF, Chicago: We wish to place in nomination the name of Andrew C. Ivy to succeed himself.

DR. ROBERT HAYES, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. A. C. Ivy. (Motion seconded by Dr. J. H. Hutton and carried).

(The ballot was cast and the President declared Dr. A. C. Ivy, Chicago, elected to the Committee on Medical Education and Hospitals for a term of three years.)

THE PRESIDENT: Nominations are in order for (c) Committee on Medical Benevolence, one member to be elected for a term of three years; the term of Lee O. Frech, Decatur, expiring.

DR. E. E. DAVIS, Avon: I wish to place in nomination the name of Dr. Lee O. Frech, Decatur, to succeed himself.

DR. L. J. HUGHES, Elgin: I move that the nominations be closed and the Secretary cast the ballot for Dr. Frech. (Motion seconded by Dr. G. Henry Mundt, Chicago, and carried).

(The ballot was cast and the President declared Dr. Lee O. Frech elected as a member of the Committee on Medical Benevolence for a term of three years.)

THE PRESIDENT: Nominations are in order for (d) Committee on Medical Testimony, two members to be elected for a term of four years; the terms of Walter L. Palmer, Chicago and Arthur F. Goodyear, Decatur, expiring. Nominations are also in order to fill the unexpired term of W. J. Gillesby of Effingham until May, 1951. Dr. Gillesby moved out of the state and Dr. M. T. Horsman of Salem was appointed by the Council to serve until May, 1950.

DR. H. K. SCATLIFF: We would like to place in nomination the name of Walter L. Palmer, Chicago, who has been invaluable in the work of this Committee. He is from the University of Chicago. (Motion seconded by Dr. O. W. Rest).

DR. E. E. DAVIS, Avon: I wish to nominate Dr. A. F. Goodyear, Decatur, to succeed himself.

DR. W. I. LEWIS, Herrin: I move the nominations be closed and the Secretary cast the affirmative ballot for Drs. Palmer and Goodyear. (Motion seconded by Dr. E. E. Davis of Avon and carried).

(The ballot was cast and the President declared Drs. Walter L. Palmer, Chicago, and Arthur F. Goodyear, Decatur, elected as members of the Committee on Medical Testimony for a term of four years.)

DR. E. E. DAVIS, Avon: I wish to nominate Dr. M. T. Horsman of Salem to fill the vacancy caused by the removal of Dr. Gillesby to another state.

DR. E. H. WELD, Rockford: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Horsman. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

(The ballot was cast and the President declared Dr. M. T. Horsman of Salem elected as a member of the Committee on Medical Testimony to serve until May, 1951.)

THE PRESIDENT: The next order of business is fixing the per capita assessment for 1951.

DR. OSCAR HAWKINSON, Chicago: The Council at its meeting yesterday recommended that the dues remain the same for one more year.

THE PRESIDENT: You have heard the recommendation, what is your pleasure?

DR. L. J. HUGHES, Elgin: I move that the recommendation be concurred in. (Motion seconded by Dr. Robert Hayes, Chicago).

DR. WALTER BORNEMEIER, Chicago: I voted against that measure yesterday in the Council. I think, generally speaking, we should raise more money than we need to. For this year we may be able to get along but I do think there are things coming along and that organized medicine will need money. I was, in view of that fact, in favor of raising the dues.

THE PRESIDENT: Any further recommendations? The question has been called for. (Motion carried).

The next order of business is the selection of a meeting place for the 1951 annual meeting.

THE SECRETARY: Mr. President and members of the House of Delegates: This matter is becoming more difficult each year to make arrangements for our annual meeting. As you all know, this is the first meeting we have had outside of Cook County in 8 years. We were most fortunate in getting the National Guard Armory for our meeting. This is the only place outside of Cook County which can accommodate our meeting. It looks for the moment as though Springfield and Chicago are the only two places in Illinois where we can hold meetings. We would need time to make arrangements. For the last 8 or 9 years it has been the policy to leave this matter to the Council for final action.

DR. ROBERT HAYES, Chicago: I would like to move that the matter be left in the hands of the Council with power to act. (Motion seconded by Dr. Harold Miller of Chicago, and carried).

THE PRESIDENT: The next order of business is the reports of Reference Committees and action upon same. The first report will be from the Committee on Reports of Officers:

DR. MATHER PFEIFFENBERGER, Alton: The Committee wishes to present the following report:

*President's Report*: We, the members of the Reference Committee, have reviewed the President's report with keen satisfaction and acclaim. We feel that he has performed a most outstanding service as President of this Society. His report reveals a comprehensive coverage showing his thorough knowledge and judgment regarding the problems of this Society. We feel that he has given an impetus to the Illinois State Medical Society which will have a lasting effect on its continued progress.

*President-Elect's Report*: Dr. Hedge's report shows that he is conversant with the activities and problems of the Illinois State Medical Society. We feel that the affairs of the Society will be in competent hands during his incumbency as President.

*Secretary-Treasurer's Report*: Our comments on the Secretary-Treasurer's report are laudatory as usual. We feel that we have the most competent Secretary-Treasurer of any society in the United States. We particularly commend the Secretary's continued coverage of current developments in the News Letter, which is a valuable innovation. His hearty cooperation with our National Society in its lay educational campaign and his work on the Rural Medical Care campaign, with Dr. English and his committee, have met a great need. The treasurer's report reflects the stability of the financial condition of our organization.

The Reference Committee considers the officers to have discharged their duties faithfully and competently, for which every member of this Society should be very grateful.

Respectfully submitted: Frank Fowler, M.D., Frank P. Hammond, M.D., Dale E. Scholz, M.D., M. Pfeiffenberger, M.D., Chairman.

DR. HAROLD MILLER, Chicago: I move the adoption of the report. (Motion seconded by Dr. Robert Hayes, Chicago, and carried).

THE PRESIDENT: The next report will be from the Committee on Reports of the Councilors. Dr. Fred Muller will make the report in the absence of the Chairman, Dr. R. C. Oldfield.

*The Report of the Chairman of the Council*: A careful survey of the material submitted by the Chairman of the Council indicates commendable enthusiasm shown in the discharge of his duties which the Society has entrusted to him. He has presented a complete report regarding the many activities of the Council during the present year and of the committees of the Council. We wish to emphasize the following recommendation in his report: "In a long range planning, it would seem that the Chicago Medical Society with the State organization could well combine their efforts and resources in securing a building properly located where office space would be adequate, where specialty societies and other groups could meet and where proper arrangements could be made for growth and expansion, for storage of records, and archives, for reading room, library and museum, and the many other needs required by organized medicine in this State. All of this could be accomplished without loss of identity by any organization. At this time unfortunately there is nothing in the forseeable future that this hope can materialize, but it is safe to predict that some one some time will recognize the great advantage of such an arrangement."

The Committee recommends the adoption of this report.

(Dr. Muller: I move the adoption of this por-

tion of the report. Motion seconded by Dr. Harold W. Miller, Chicago, and carried).

*The Report of the Councilors of the Eleven Districts.* The reports of the eleven councilors have been carefully reviewed and we commend the councilors individually for their work in the discharge of their duties as Councilors. The Committee suggests the Councilors' reports contain more information about the activities initiated and carried on by their county societies.

The Committee recommends the adoption of this part of the report.

(Dr. Muller: I move the adoption of this portion of the report. Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

*Report of the Councilors At Large*: The Councilors at Large are to be commended for their interest in all phases of organized activities and their help in the welfare of state and county societies. The Committee notes the fact that only two of the three Councilors at Large have reported.

The Committee recommends the adoption of this part of the report.

(Dr. Muller: I move the adoption of this portion of the report. Seconded by Dr. E. E. Davis of Avon, and carried).

Respectfully submitted, C. Ellsworth Black, M.D., Fred H. Muller, M.D., J.J. Grandone, M.D., R. C. Oldfield, M.D., Chairman.

(Dr. Muller: I move the adoption of the report as a whole. Motion seconded by Dr. F. Lee Stone, and carried).

THE PRESIDENT: The next will be the report of the Committee on Reports of the Standing Committees by Dr. Charles H. Phifer:

*Report of the Committee on Medical Service and Public Relations*: Your Reference Committee has carefully reviewed this very excellent report. In view of the controversial problems that confront American medicine today this report constitutes one of the most important reports presented to your House of Delegates. It deserves the careful attention of every member of our organization. It gives to the members of the Illinois State Medical Society an informatory statement regarding some of the many diversified, constructive and intensive activities of this Committee during the past year as well as the part your Society has taken to assist in the national campaign against socialized medicine.

Your Reference Committee greatly appreciates the manner in which this work has been carefully planned and organized, likewise its study and careful consideration of all pending and proposed local, state and national legislation as to its benefits or detriments to our people.

Your Reference Committee thoroughly endorses all of their activities with reference to aiding the national educational campaign of medicine through their multitudinous presentations. These have been accomplished by personal contacts, by conversations through physicians and patients, either personally or collectively, speakers' bureaus, public addresses, press, radio, television, pamphlets, periodicals, magazines, churches, newspapers, women's auxiliaries, resolutions and letters. Many of these talks have been directed to various lay organizations, labor, industry, clubs of all kinds, parent teachers associations and many different organizations, always calling their attention to the great merits derived by the people of this country through private enterprize in medicine and the value of maintaining the private patient-physician relationship through their family physicians. In these presentations an inexhaustible supply of knowledge has been given concerning the fallacies of the much talked of ideologies of socialized medicine and the Welfare State.

We move the adoption of that part of the report.

(Dr. Phifer: I move the adoption of this portion of the report. Motion seconded by Dr. Gentz Perry of Evanston and carried).

Your Reference Committee desires to commend your Committee on Medical Service and Public Relations for their very excellent publicity in connection with the election of Dr. Andy Hall of the State of Illinois as the most outstanding distinguished general practitioner of the year of both the state and the nation. Dr. Andy Hall has long been held in very high esteem by the citizens of his community and the members of the medical profession of this state. He has made great contributions in medicine in the State of Illinois. Dr. Hall's distinguished recognition as the outstanding general practitioner of the State of Illinois and the American Medical Association is a compliment to Dr. Hall and the Illinois State Medical Society. His qualifications as a man and a distinguished physician will long serve as a prototype that will be hard for other medical societies to emulate.

We move the adoption of this part of the report.

(Dr. Phifer: I move the adoption of this portion of the report. Motion seconded by Dr. Harold Miller, Chicago, and carried).

*Political Activities*: To that part of the Committee's report captioned "Political Activities" your Reference Committee thoroughly concurs in the statement of the Committee that medical societies as corporations are barred by law from contributing funds or services to support any candidate for Congress or the Legislature. The fact however remains that we as individual physicians and citizens have a legitimate right to oppose the great movement of the socialization of this country as well as the practice of medicine.

Your Reference Committee supports the opinion of your Committee on Medical Service and Public Relations in that as individuals we have the same privileges that other citizens do in helping to influence and elect legislative members who are charged with making the government policies of our state and country. We, therefore, concur in the recommendations of this Committee to the effect that every physician and member of his family should register and take an active part in fighting and voting to help defeat the progress of the Welfare State that now confronts us.

We move the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this por-

tion of the report. Motion seconded by Dr. F. L. Stone, Chicago and carried).

Signed, Frank Deneen, M.D., Frank F. Maple, M.D., B. E. Montgomery, M.D., Charles H. Phifer, M.D.

(DR. PHIFER: I move the adoption of the report as a whole. Motion seconded by Dr. E. E. Davis, Avon, and carried).

*Report of the Committee on Medical Education and Hospitals.*

Your Reference Committee has carefully read this very comprehensive and detailed report of your Committee on Medical Education and Hospitals. We are pleased to note that some progress is now being made in the State of Illinois in the construction of hospitals under public law 725 and that there are now, by reason of its benefits, about 1,390 hospital beds either under construction or in the near process of same.

Your Reference Committee would like to state that while there is such an acute shortage of hospital beds that every hospital should give very careful consideration to the number of patients in their hospital who are chronically ill and who are occupying beds that should be utilized by the acutely ill. Careful planning can avoid much of the latter. In many instances some of these chronically ill patients occupy beds for months and months when they could be just as well cared for in other well-regulated institutions, thereby making available beds for the acutely ill that are in such serious need of hospitalization. In this connection in the City of Chicago a committee of the Institute of Medicine on chronically ill has now functioned over a period of five years in which they have endeavored to make possible the efficient use of existing facilities and services for the care of the convalescent and chronically ill patients in other institutions. The same committee has likewise furthered the development of more additional facilities for the chronically ill. They have stimulated interest in the proprietors of convalescent or nursing homes to raise their type of nursing care as well as dietetics. In view of the work of this committee a number of hospitals and convalescent homes are building units designed for the care of the chronically ill so that the physician may take care of these patients in that institution with just as good care as provided in other hospitals. This has been a very constructive project. What has been done by this committee can be done in other communities, namely by improving the type of care in our nursing homes and other institutions so that they may be utilized for the good of long termed convalescent or chronically ill patients. The constructive use of these principles will not only provide good care but will make available many beds in our hospitals so that it will be possible for their physical plants to accommodate many more acutely ill patients.

Your Reference Committee moves the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

Your Reference Committee notes the report of the Committee in reference to the role of our hospitals in medical education. This is a very important responsibility of every hospital and the members of its staff. It is an obligation we owe our interns and residents, and in these days with the great shortage of interns we cannot hope to secure an adequate supply of interns if we fail in our obligation to provide a medical education training program for them. Every member of the staff should assume his obligation in helping provide this training.

Your Committee moves the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. F. Lee Stone, Chicago, and carried).

Your Reference Committee is pleased to note that part of the report that refers to the management of hospitals being placed largely in non-medical hands. This is a very important problem today. Many of the hospital governing boards are self-perpetuating. Hospitals are dependent upon physicians. The success of every hospital depends upon the type and qualifications of the medical care rendered by its medical staff. Each of these physicians carries an important role as a part of the hospital and as a representative physician in his community. Most physicians, regardless of the common statement to the contrary, are good business executives. It is very possible that part of this trouble arises from the fact that members of their medical staffs are frequently very busy and inclined to avoid accepting responsibility in reference to management. It is, however, a responsibility that every physician owes to his hospital and he should assume that responsibility regardless of his personal sacrifices.

Your Committee moves the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. W. E. Kittler, Rochelle, and carried).

Your Reference Committee regrets to state that again this year, as it did last year, the Committee stressed the need for a hospital in the West Side Medical Center to care for the private patients of the clinical staff of the College of Medicine of the University of Illinois, stating that at the present time the members of the clinical staff must take their private patients to hospitals all over the city of Chicago and that it is the hope of their Committee that the Illinois State Medical Society will see its way clear to support the development of such a hospital in that community.

Your Reference Committee desires to state that this is a controversial question and that the Reference Committee has no desire to enter into the controversy, in its present state. To approve the report of the Committee without some comment would be tantamount to its approval. We therefore believe that to recommend the approval of a problem of this type without more information regarding the question would not be proper. This is not a request from the University of Illinois. There is nothing in this report to intimate how this institution would be operated. The question of hospitals practicing medicine is one that has been discussed

in several recent meetings of the House of Delegates of the American Medical Association.

Your Committee is certain that there are delegates in this House of Delegates who will recall the long legislative controversies in the State of Illinois at the time the College of Physicians and Surgeons became an integral part of the University of Illinois and State funds were asked to support that institution. Much of which was due to the opposition of physicians who feared the University would enter into the private practice of medicine. In considering this request thought should be given to the fact that this is a very large faculty, composed of over 800 different teachers. Some of them are, by reason of contract of agreement with the University, on a full time compensation basis and are prohibited from participating in the private practice of medicine. The majority of all teachers reside in near or far sections of the City. Many of these teachers have their own private practice in their own communities and are affiliated with hospitals in their sections of the City. In many instances some of these teachers may only give an hour or two a week for a semester to teaching and may not be teaching during the next semester. It is thus evident that the time that these instructors devote to teaching at the University depends upon the individual man and his subject assignment.

Your Reference Committee appreciates the fact that some medical schools have such facilities. The operation of each of these depends upon the medical policy that governs the operation of the hospital. It is the policy of some institutions to practice medicine. Their problems are very different in that the members of the Faculty are all full time men and that regardless of the number of private patients they may see, the Compensation arriving from the care of these patients go into the general University fund. It is thus evident that to approve this part of the report without further information is neither fair to the University of Illinois nor this House of Delegates.

It is your Reference Committee's recommendation that if and when the University of Illinois desires the approval of the House of Delegates of the Illinois State Medical Society on this subject that it should present a carefully outlined program of what it contemplates in the way of the building and what its medical policies would be in reference to operating such institution. This is the only way in which in the opinion of your Reference Committee this problem should be considered by the House of Delegates.

Your Reference Committee moves the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. F. Lee Stone, Chicago).

DR. W. O. THOMPSON, Chicago: The Committee on Medical Education and Hospitals outlined the needs of the various medical schools in Chicago and the need of a University Hospital for a private hospital was stressed along with the needs of the other schools. The Committee did not intend that any formal action would be taken at this time. They wanted to call the problem to the attention of the House of Delegates. However, I can give you some information of what the University of Illinois has in mind. As you know, the clinical faculty is composed of part-time men who receive no salary from the University. The University has no intention of developing a full-time medical staff, nor does it have any intention of developing a pay clinic. It may add a few more full-time men as staff vacancies become available but the majority of teaching will continue to be done by the men who receive no salary. At the present time these men must take their private patients to hospitals all over the city of Chicago. Chicago is a large city and covers a large geographic area. Dr. Keeton, head of the Department of Medicine, has to go to St. Francis Hospital, Evanston, to St. Luke's Hospital, Chicago and then back to the West side to teach. If all the hospitals and teaching were on one side of the city time would be saved. The plan that has so far been brought forth is to develop a private hospital with private patients run by an individual Board of Trustees, in other words, not run by the University of Illinois. It is merely suggested that private substance will be contributed to such a possibility and the state itself would consider whether it should help in such a development. However, all the discussion has concerned itself with a private institution run by a separate Board of Trustees. The thing which I wish to make clear is that the University has no intention of entering into the full time practice of medicine or to change its present set-up materially.

THE PRESIDENT: Any further discussion on this portion of the report? The question is called for. (Motion carried).

Your Reference Committee notes the report in reference to group practice, the nursing problem, health insurance and postgraduate medical education which we are pleased to endorse and we move the adoption of this portion of the report.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. F. Lee Stone and carried).

*Medical School Problems*: Your Reference Committee is pleased to note that part of the report regarding the medical school problems and the change from private schools to merging with state universities. We appreciate that there are two basic reasons for this. One of them is the increased opportunity for teaching facilities and second, and more important, the question of finance.

Your Reference Committee hopes that all our medical schools will be able to adequately finance their institutions without government subsidies, and thus avoid another step towards the Welfare State.

We move the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this por-

tion of the report. Motion seconded by Dr. Percy E. Hopkins, Chicago, and carried).

Your Committee moves the adoption of the report as a whole.

Signed: Frank Deneen, M.D., B. E. Montgomery, M.D., Frank F. Maple, M.D., Charles H. Phifer, M.D.

(DR. PHIFER: I move the adoption of the report as a whole. Motion seconded by Dr. W. E. Kittler and carried).

*Report of the Committee on Medical Benevolence*: Your Reference Committee commends to the members of the Illinois State Medical Society and the members of the medical profession the very excellent, constructive and complimentary report of the work of this Committee. It is your Reference Committee's opinion that the dreams and objectives for which the function of this Committee was created a few years ago has been realized by the manner in which it has been able to minister so helpfully and timely to the less fortunate members of the profession. We appreciate that it not only gladdens the hearts of those who receive its benefits but it must be a source of great satisfaction to the members of the profession who have sponsored this project and managed it during and since its orgin.

Your Committee recommends the adoption of this part of the report.

(DR. PHIFER: I move the adoption of this of the report. Motion seconded by Dr. Oscar Hawkinson, Chicago and carried).

Your Reference Committee commends the Women's Auxiliary for their very constructive assistance in this project and we recommend that the House of Delegates of the Illinois State Medical Society now in session request the Secretary of the Illinois State Medical Society to write to the Woman's Auxiliary of the Illinois State Medical Society expressing our great appreciation for their timely and constructive assistance in this benevolent function.

(DR. PHIFER: I move the adoption of this portion of the report. Motion seconded by Dr. G. Henry Mundt and carried).

Your Reference Committee recommends the adoption of the report as a whole.

Signed: Frank Deneen, M.D., B. E. Montgomery, M.D., Frank F. Maple, M.D., Charles H. Phifer, M.D.

(DR. PHIFER: I move the adoption of the report as a whole. Motion seconded by Dr. G. Henry Mundt, Chicago, and carried).

*Report of the Committee on Medical Testimony*: Your Reference Committee is pleased to note that the work of this Committee's assignment is getting organized and that there has been less work for the Committee during the past year. We are happy to know there is affable liaison committee composed of an equal numbers of the Chicago Bar Association and the medical profession in personal injury suits and litigation.

It is the opinion of your Reference Committee that with the careful, diligent work of this Committee and with tact and diplomacy on the part of members of the legal and medical professions that many embarrassing complications and legal experiences can be averted on eliminated. Your Committee on Medical Testimony is to be commended for its excellent work.

Your Committee moves the adoption of this report.

Signed: Frank Deneen, M.D., Frank F. Maple, M.D., B. E. Montgomery, M.D., Charles H. Phifer, M.D.

(DR. PHIFER: I move the adoption of this report. Motion seconded by Dr. P. E. Hopkins and carried).

*Report of the Committee on Archives*: Your Reference Committee is delighted to note the wonderful progress that is being made by this Committee and Miss Salmonsen in collecting the data for the second volume of history of the Illinois State Medical Society. The State of Illinois, located as it is geographically, with its great pioneer medical history, diseases peculiar to its location, the effect of sanitation on the occurrence of disease, reduction of mortality, its diversified industries, urban and rural communities, and its medical centers with their contribution to medical education, constitutes a great chapter in medical history.

This Committee deserves the support of every member of the medical profession and the citizens of this state in helping to secure all the informative data that is available to aid in compiling this history.

Your Reference Committee recommends the adoption of this report.

Signed: Dr. Frank Deneen, Dr. Frank F. Maple, Dr. B. E. Montgomery, Dr. Charles H. Phifer.

(DR. PHIFER: I move the adoption of this report. Seconded by Dr. F. Lee Stone, Chicago and carried).

*Report of the Medico-Legal Committee*: Your Reference Committee desires to compliment the Medico-Legal Committee for this very efficient report. It is a report that should concern every member of the profession in this state. Physicians should remember that caution, tact and diplomacy in reference to all cases at all times will not only lessen the work of this Committee, but provides the fundamentals for a happy and harmonious working relationship between the members of our profession.

Your Committee recommends the adoption of this report.

Signed: Frank Deneen, M.D., Frank F. Maple, M.D., B. E. Montgomery, M.D., Charles H. Phifer, M.D.

(DR. PHIFER: I move the adoption of this report. Seconded by Dr. W. E. Kittler, Rochelle, and carried).

DR. PHIFER: I move the adoption of the reports as a whole. (Motion seconded by Dr. Frederick Slobe, Chicago, and carried).

THE PRESIDENT: The next report will be from the Committee "A" on Reports of Council Committees, to be presented by Dr. Frank M. Hagens.

*Report of Reference Committee "A" on Reports of Council Committees.*

*Educational Committee*: Your Reference Committee approves the report of this committee, which covers the activities during the past year, by imparting practical and sound information on health education to the

public. The continuance of the projects now being pursued is suggested in the form of 1) Television 2) Health Talks 3) Publicity and Press 4) Speaker's Bureau 5) Radio. The Committee has endeavored to broaden its educational scope for good health and to reflect the integrity of the medical profession.

(DR. HAGENS: I move the adoption of this portion of the report. Motion seconded by Dr. Fred Muller, Chicago and carried).

*Scientific Service Committee*: The year 1949-50 has been active, satisfactory and progressive. Twenty-six county medical societies were serviced and a total of 136 speakers were scheduled. In addition to the county society service, four speakers were scheduled for the Northwest Chapter of the Academy of General Practice and one each for Illinois Chapter American Academy of General Practice, Iowa and Illinois Central District Medical Association, Chicago Oral Surgical Society and Stock Yards Branch of the Chicago Medical Society, giving a total of 138 speakers.

(DR. HAGENS: I move the adoption of this portion of the report. Motion seconded by Dr. W. B. Stromberg, Chicago, and carried).

*Fifty Year Club*: The membership continues to increase. At the present, the club has 383 members, 228 downstate and 155 in Chicago. Under the continued guidance of our honored member and chairman, Andy Hall, the interest in such an organization has stimulated similar organizations in several of our nighboring states. It is the custom each year to invite every member of the club to attend a complimentary banquet given by the State Society. By this means it serves to renew old friendships and an enjoyable hour together.

(DR. HAGENS: I move the adoption of this portion of the report. Motion seconded by Dr. Karl L. Vehe, Chicago, and carried).

*Committee on Medical Economics*: The committee presents its report, and with it a frank expression that it has not fulfilled its objective of contributing one article per month to the Illinois Medical Journal, — and suggests a decision be made by the House of Delegates as to whether it should continue to attempt to function, — or a new method be sought to obtain monthly articles for the Medical Economics column in the Journal.

DR. HAGENS: I move the adoption of this portion of the report. Motion seconded by Dr. F. Lee Stone, Chicago, and carried).

*Physical Therapy*: Due to the death of Dr. John H. Coulter, chairman of the committee, the activities of the committee have been limited. However, all literature on therapy has been covered and abstracts supplied to the Journal. The report was submitted by Emil Hauser for the Chairman.

(DR. HAGENS: I move adoption of this portion of the report. Motion seconded by Dr. Karl L. Vehe, Chicago, and carried). Respectfully submitted, Frank M. Hagans, M.D., Chairman, D. H. Trumpe, M.D. Elmer V. McCarthy, M.D.

(DR. HAGENS: I move the adoption of the report as a whole. Motion seconded by Dr. Harold W. Miller, Chicago, and carried).

THE PRESIDENT: The next report will be from Committee "B" on Reports of Council Committees, to be presented by Dr. G. Henry Mundt.

*Report of Reference Committee "B"*:

1. Report of Advisory Committee Survey on Child Health American Academy of Pediatrics.

Your committee is pleased to note an abstracted report on the state survey on child health service will probably be published soon.

2. Report on the Committee on Fetus and Newborn.

The committee calls attention to the availability of the manual "Standards and Recommendations for Hospital Care of Newborn Infants Full Term and Premature," This manual may be procured from Clifford G. Grulee, M.D., 636 Church Street, Evanston, Illinois for fifty cents.

Your Reference Committee notes that under minimum requirements as to the professional qualifications of the pediatric Staff and the conduct of the new born nursery that the committee has with wisdom made it acceptable for a physician not certificated in pediatrics to serve in this capacity.

Your Reference Committee feels that under consutation in the report where it is stated that under certain circumstances the physician must ask for consultation it would be better to substitute the word "should" for the word "must".

Your Reference Committee moves the adoption of this portion of the report.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. F. Lee Stone, Chicago, and carried).

Report of the Medical Advisory Committee to the Illinois Public Aid Commission.

Your Reference Committee urges that this report be read by the members of the House as it explains many of the difficulties facing the Public Aid Commission, Medical Advisory Committee to the Illinois Public Aid Commission and the practitioners of medicine.

The committee submitted a supplementary report in which it states that the Commission has changed its ruling on hospital admittances. The committee will shortly meet with the Commission to work out the problem of drugs, etc. etc.

Because the almost certain deficit of 18 million dollars and perhaps 25 million for the biennium it has been impossible to increase the physicians' fees this year. Your Reference Committee agrees with the Medical Advisory Committee to the Illinois Public Aid Commission that the I. P. A. C. has been very understanding in a difficult situation and that the House of Delegates of the Illinois State Medical Society, as well as the membership should know this.

The Committee calls attention to the fact that there is a rider attached to H. R. 6000, which will authorize direct payment if it passes. With wisdom

the Committee states "What additional problems and complications this will bring only the future can tell."

Your Reference Committee commends both the Illinois Public Aid Commission and the Medical Advisory Committee to the Illinois Public Aid Commission in working toward a satisfactory solution in a very difficult field.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. L. J. Hughes, Elgin).

THE PRESIDENT: It has been moved and seconded that the report be adopted. I will ask Dr. Coleman if he has any report.

DR. E. P. COLEMAN, Canton: Two months have elapsed since the original report published in the official reports was made. Since then several things have occurred which have complicated the situation quite considerably.

Due to the increasing certainty of a greater shortage of funds occasioned by between 0 and 15 per cent increase in people who have gone on relief because of unemployment, the deficit for the biennium is now calculated in figures varying from 14 to 25 million dollars according to who makes the estimate. In an election year it is quite obviously not going to be a popular procedure to ask for an additional session of the legislature to vote additional taxes for this purpose although additional tax funds may be required, and probably will be, at the beginning of next year. As a result of this problem the Public Aid Commission has made desperate efforts to cut down its overhead and in addition to curtailing the funds allocated for food, shelter, clothing, and so on, is attempting to cut down on the amount of expense in hospitalization and also in the use of drugs. This is particularly important to the Commission because of the tremendous increase in the use of the various antibiotics which are quite expensive. As a result there has been a two weeks limitation on cases for hospitalization and recently a demand that all cases have preauthorization before being hospitalized. Furthermore, for a period of several months, particularly the last two months, efforts have been made to check the cost of drugs dispensed with the intention of reducing expenses in this particular field. This has led to the issuing of several new directives which have perhaps been effective from the standpoint of curtailing expenses but which have also been very annoying and irritating to the medical profession. It has increased the irritating annoyance factor to quite a degree and as a result a great many protests have been received throughout the state.

The Advisory Committee, at a recent meeting with the Commission, was able to get the ruling for preauthorization for hospitalization of Public Assistance recipients rescinded to this extent: — it is now in the hands of the local Advisory Committees and they can continue it if they wish to. Therefore, it may be continued in some counties if it meets with local medical society approval whereas, in counties where it has met with objection and resistance, it will go back to the former method.

A meeting is already planned between the Advisory Committee and the Commission for the following week at which time it is hoped to get a more liberal attitude on the part of the Commission toward the price of dispensed drugs, especially antibiotics. In order to affect this, your Committee would appreciate a resolution from the House of Delegates directing us to ask for a readjustment of the prices of drugs, and antibiotics in particular.

THE PRESIDENT: Thank you Dr. Coleman. Will you bring that up under the head of new business. All in favor of adopting the motion to accept this portion of the report signify by the usual sign. (Motion carried).

DR. MUNDT: That portion of the report has been approved but I want to call your attention to this sentence beginning H. R. 6000, "What additional problems and complications this will bring only the future can tell."

*Report of the Committee on Construction and By-Laws*: In addition to the changes suggested in the 1950 official annual reports of officers and committees the Committee has recommended a further change in by-laws to clarify and agree with the recently changed by-laws of the American Medical Association.

Amend Chapter 11, Section 10 of the By-laws by deleting the last sentence and amend by adding:

"An active member who is delinquent in the payment of dues for one year shall forfeit his active membership if he fails to pay the deliquent dues within thirty days after notice of his deliquency has been mailed, by the Secretary of his component society, to his last known address."

Your Reference Committee approves the changes suggest by the Committee on Constitution and By-laws.

DR. MUNDT: Your Reference Committee feels that everything is in the state of flux throughout the country. It is well enough to adopt this change in the By-laws at this time but I recognize that at the end of another year the thing will need clarifying. Your Reference Committee at this time would recommend that we adopt this change in the By-Laws.

DR. W. E. KITTLER: If you are going to change the By-Laws why not let it lay over.

DR. WARREN FUREY: We are not adopting the amendment, we are recommending a change. The By-Laws at the present time say that if a man is delinquent he is automatically dropped as of December 31. The A.M.A. By-Laws state that he is not dropped until after one year plus 30 days grace. A man could still be a member of the A.M.A., having been dropped by this organization, according to our present by-laws.

DR. MUNDT: I move the adoption of this recommendation. (Motion seconded by Dr. Fred Muller, Chicago, and carried).

*Report of the Committee on Mental Hygiene*: Your Reference Committee approves the report of this

committee and calls attention to the last sentence in the last paragraph of the report, "The Committee deplored the prolonged waiting for admission to these institutions. It urged that the Illinois State Medical Society take action to remedy this condition." Your Reference Committee knows no method whereby the Illinois State Medical Society could remedy this situation and respectfully asks that the Committee continue its study of the many problems and if they have any suggestion before meeting in 1951 that it be referred to the Council of the Illinois State Medical Society.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. Oscar Hawkinson, Chicago, and carried).

*Report of the Committee on Voluntary Prepayment Plans for Medical and Surgical Care*: The committee has made a very commendable report. A supplemental report was submitted in which the committee calls attention to the fact that there are four plans now functioning in the State of Illinois, Blue Shield Medical Surgical Plan, at Alton, Northern Illinois Medical Service Corporation, at Rockford, Illinois Medical Service, in Chicago, and Rock Island County Medical Service.

All of these plans have not been approved by the House of Delegates of the Illinois State Medical Society and it is the opinion of the committee, as well as your reference committee, that they should be approved. I so move.

The committe further recommends that the House encourage all county societies to exert their best efforts in prepayment care field.

Your Reference Committee heartily approves this.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. Robert H. Hayes, Chicago, and carried).

Respectfully submitted, Charles Allison, M.D., S. M. Goldberger, M.D., David B. Freeman, M.D., G. Henry Mundt, M.D., Chairman.

(DR. MUNDT: I move the adoption of the report as a whole. Motion seconded by Dr. W. E. Kittler, Rochelle, and carried).

THE PRESIDENT: We will now hear the report of the Reference Committee "C" on reports of Council Committees. Dr. J. H. Edgcomb will give the report.

*Report of Committee on Venereal Disease Control*: This Committee submits a favorable report and the number of venereal cases reported to the department shows a decrease. We trust that this is not due to the negligence of the profession in reporting cases to the Health Department. We approve the program of Public Education and feel that it should be continued. The training of nurses in nursing technique in this field is to be commended.

(DR. J. H. EDGCOMB: I move the adoption of this portion of the report. Motion seconded by Dr. E. H. Weld, and carried).

*Report of Advisory Committee to the Veterans Administration*: This Committee is to be congratulated on the satisfactory relationship they have maintained with the Veterans Administration. We are sure any reorganization they may recommend will be for the good of all. It seems to us that the financial renumeration for the services rendered is reasonable. Dr. Cockrell is to be commended for his willingness to cooperate in every way in this work.

(DR. EDGCOMB: I move the adoption of this portion of the report. Motion seconded by Dr. Harold Miller and carried).

*Report of Committee on Cancer Control*: This Committee feels we can heartily endorse this report in all of its phases. The lay educational program including Dr. Jones, exhibit at the Museum of Science and Industry is excellent. We feel the program is well organized and effectively carried out. The cancer detection centers are doing good work and we feel the program should be continued. The program of Professional Education is well received by the physicians throughout the state and those that have attended these courses feel they are well repaid for the time spent. We are happy to note the success of the financial campaign.

(DR. EDGCOMB: I move the adoption of this portion of the report. Motion seconded by Dr. Harold Miller and carried).

*Report of Committee on Military Affairs and Emergency Medical Service*: The meat of this report is in the supplementary report. We heartily endorse it and think that the County Societies should be appraised of the importance of education at their level and of the care they should exercise in selecting the County Chairman and of being sure that he continue to function. We approve of the Regional meetings they suggest, also their suggestions in reference to the including of talks on this subject in all postgraduate conferences. The Committee is to be commended for its activities which were seriously hampered by delays in the submission of a program at the higher levels. We approve the appointment of Dr. Cross in this committee.

(DR. EDGCOMB: I move the adoption of this portion of the report. Motion seconded by Dr. Frederick Slobe, Chicago, and carried).

*Report of Committee on Tuberculosis*: The excellent report of this committee is endorsed. We are pleased to note that the State of Illinois is appropriating money for a field of endeavor in which so much can be accomplished if the funds are available.

We feel that those counties that are interfering with the Mobile Unit program by insisting on preliminary tuberculin tests are not cooperating as well as they might. We are pleased to note the continued downward trend of tuberculosis in the state and are sure that it will continue if the proper support is put behind the men in this field. We note the statement of the committee that there are no startling innovations in the success of new drug therapy in tuberculosis and feel that this message should be carried to the profession at large, also the fact that they recognize the family physician as the keystone in tuberculosis control.

(DR. EDGCOMB: I move the adoption of this portion of the report. Motion seconded by Dr. Robert Hayes, Chicago, and carried).

Signed: J. H. Edgcomb, Chairman

(DR. EDGCOMB: I move the adoption of the re-

port in its entirety. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

THE PRESIDENT: We will now have the report of Committee "D" on the Reports of Council Committees, Dr. J. H. Hutton presenting the report.

*Report of the Committee on Industrial Health*: Your Reference Committee approves the vigilance with which this Committee has studied the problems of industrial health. It recommends that the House approve the report as published in the Handbook, also the supplementary report presented at the first meeting of the House of Delegates by Doctor Chivers. We recommend that the House take such steps at is deems advisable to see that the recommendations named in these reports are effectively implemented.

DR. J. H. HUTTON: Dr. Slobe has a very definite recommendation as to how we may implement this survey. I would like to move the adoption of this portion of the report and ask the approval of the floor for Dr. Slobe. (Motion seconded by Dr. Harold Miller).

DR. FREDERICK SLOBE, Chicago: I am sure that those who heard Dr. Chivers' report realize that there are important implications involved in this matter. Those of us who have been members of the Governors' Advisory Committee to the Division of Industrial Hygiene have become increasingly cognizant of this during the past few years. The House of Delegates took action concerning this several years ago and, I believe, should reaffirm and still further clarify its attitude at this time. Accordingly, I move that this House of Delegates recommends and approves of the introduction of appropriate legislation at the next General Assembly of the State of Illinois specifically confining and limiting industrial hygiene and health activities to the Department of Public Health, and that it further recommends that copies of this action be sent to the Governor, the Lieutenant Governor and members of the House and Senate Legislature. (Motion seconded by Dr. James H. Hutton and carried).

DR. J. H. HUTTON: I move the adoption of this portion of the report. (Motion seconded by Dr. L. J. Hughes, Elgin, and carried).

*Report of the Maternal Welfare Committee*: Your Reference Committee compliments the work of this Committee and approves this report. It is particularly pleased with the suggestion that an Obstetrical Committee be set up in each hospital, and that the Maternal Welfare Committee does not recommend the publicizing of its findings.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried).

*Report of the Committee on Ethical Relations*: We commend this report and are as pleased as the committee that its services have been in so little demand.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. Louis Plzak and carried).

*Report of the Committee on Rural Medical Service*: In our opinion this is one of the most important activities of the Society. The report indicates that the work is being efficiently carried on by the Committee. We heartily recommend the adoption of the report of this Committee.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. L. J. Hughes, Elgin, and carried).

*Report of the Committee on Crippled Children's Clinics*: No member of this committee appeared before the Reference Committee. This appears to be progress report and should be adopted as such.

Review history; contagious disease; mental disease; cancer; heart disease; diabetes. We socialize one disease at a time.

Respectfully submitted, James C. Ellis, M.D., DeKalb; Robert Mustel, M.D., Chicago; T. G. Knappenberger, M.D., Champaign; James H. Hutton, M.D., Chicago, Chairman.

DR. J. H. HUTTON: The Committee recommends the adoption of this report. But before the House votes on this motion I would like to make a few remarks.

We tend to socialize medicine one disease at a time. Since at least as early as 1817 we have recognized contagious disease as a public responsibility and have put its management under government control in various ways. For nearly a century we have recognized mental disease as a social problem to be treated by methods of socialized medicine.

On the Sunday following the first acceptance speech by the late Mr. Roosevelt, Dr. John R. Neal called a meeting in this hotel. The purpose was to forestall some state action concerning crippled children's clinics. We have now accepted these clinics and have a committee to look after them.

The cancer clinics, or tumor clinics, or cancer detection centers—by whatever name we wish to call them—have a tendency to socialize this disease and in a very undesirable way. Cancer is a terrible disease and we should exert every possible effort to get rid of it. But at this time we do not know its cause; we do not know how it spreads or even whether it spreads; our methods of treatment, for the most part, are far from satisfactory. The tendency of these clinics is to destroy confidence in the private doctor. That is bad, of course, for the doctor; but it is much worse for the public. After all, most of the medical care in this country will continue to be rendered by men in private practice. Their task will be made more difficult and their work less satisfactory by anything that raises the suspicion in the mind of the patient that the doctor is not competent. As these clinics are presently conducted and publicized, they tend to do just that thing.

Recently a Cancer Bulletin pointed out that in many cases patients waited from two to six months to be examined in a cancer clinic. They might have had the same examination by their own doctor without any waiting. But the clinics have already persuaded that their doctor is not competent to make such an examination. We are told that cancer should be recognized at the earliest possible moment, and no one questions the wisdom of that statement. Then teaching the public to wait two to six months is certainly doing them no

favor. If we are not careful, heart disease and diabetes will fall into the same category. After all, a doctor acquires no special skill simply because he happens to work in a cancer clinic.

(Motion seconded by Dr. L. J. Hughes, Elgin).

THE PRESIDENT: The Chair would like to make a report about crippled children. In my own community they will see them the first time and after that they are referred to their family physician with the report. (Motion carried).

The next report will be from the Committee to report on the Editors' Report, the Committee on United Mine Workers, Committee on Scientific Work and on the Advisory Committee to the Woman's Auxiliary. Dr. Ralph McReynolds will make the report.

*Report of the Reference Committee on the Editors' Report*: In regard to the question raised regarding the publishing of the minutes of the House of Delegates in full or in abstract, your Committee feels that the minutes should be published in full—this is in the interest of accuracy. The proceedings of the House of Delegates are of such prime importance in building up the morale, and maintaining it that the entire membership of this organization should have the privilege to refer to these reports when desired at any future date.

This Committee concurs with the Editors in presenting many short papers, rather than longer and detailed papers.

The Committee compliments the Editors on the progress that they have made in publishing a journal that is informative, easy to read, and attractive.

Respectfully submitted, Ralph McReynolds, Chairman, Karl Vehe, C. Paul White, Harry J. Dooley.

DR. RALPH MC REYNOLDS: I move the adoption of this part of the report. Motion seconded by Dr. P. E. Hopkins.

THE SECRETARY: This matter of printing the Transactions of this House of Delegates was discussed by the Council at its meeting some two weeks ago. It was recommended by the Council to the House that instead of publishing the Transactions in two consecutive issues of the Journal that they be published in one booklet as a supplement to the Illinois Medical Journal either in July or August. In view of the fact that all material for the Journal each month must be in the hands of the printer on the 14th of the preceding month it is necessary, if it is approved that the minutes be published in a supplement, to do so, in August. Mr. Chairman, you did not have this information and I wonder if you would be willing to accept this as a supplementary report.

DR. MC REYNOLDS: Would it be more expensive and would every member get the supplement?

THE SECRETARY: Every member would get the report. The reason is that we have three issues each year which must carry material from the State meeting. The April issue must carry the complete program for this meeting and that takes almost the entire Journal, then in July the first meeting of the House of Delegates with all the annual reports almost entirely fills the number. Then the second meeting in August takes the third one which means that one-fourth of our Journal each year contains material other than the scientific papers. The expense would be somewhat greater than if the Transactions were published in two issues of the Journal but I think it would be compensated for by the amount of scientific material which we could publish in the Journal.

DR. C. PAUL WHITE: As a member of the Reference Committee I think the spirit was to have a total printing and not a resume of the proceedings because we felt that the members of the House of Delegates should be able to refer to any particular communication that had been handled in the House. Now according to our Secretary's information it suggested to publish a supplement. I think this Committee likewise agrees with Dr. McReynolds' suggestion that there should be a supplement made. The thing we are trying to get away from is that we do not want to have some man or group of men edit the annual resolution passed by this House. We thought we should know exactly what occurred. If that is satisfactory to Dr. McReynolds I would like to supplement this report by making a motion that the proceedings of the House of Delegates shall be printed and sent as a supplementary report to the Journal, or published in the Journal itself.

THE PRESIDENT: The Council intended that the Minutes be sent to each member of the Society in toto and not abstracted, but just as they happened here.

Dr. White's motion is out of order. There is another motion before the House. I shall rule that this motion to adopt the report be adopted as supplemented by the Chairman. (Motion carried).

*Report of Reference Committee on the Committee on the United Mine Workers*: We feel that the Advisory Committee to the United Mine Workers Welfare and Retirement Fund is doing an exceedingly important work in maintaining liaison between the physician and a large labor group, and recommends that they be continued. A supplementary report by the Committee is to the effect that the United Mine Workers Welfare and Benevolence Fund is about ready to begin operation again, probably within the next three months. They will start limiting the activity to hospital care only. This must have prior authorization. They hope to expend their activities in this field at a later date.

Respectfully submitted, Ralph McReynolds, M.D., Chairman, Karl Vehe, M.D., C. Paul White, M.D., Harry J. Dooley, M.D.

DR. MC REYNOLDS: I move the adoption of this portion of the report. (Motion seconded by Dr. Robert Hayes and carried).

*Reference Committee on the Committee on Scientific Work*: We wish to compliment the Committee for the splendid work that has been done in obtaining and of raising the scientific exhibits in both the still and the movies in such an attractive and instructive manner.

We feel that scientific papers are of outstanding merit. We further compliment the Committee on Scientific Work for the excellent content and arrangement of the program. Your Committee noticed the

interest of the Society members in the scientific exhibits and also recognizes the importance of visual education. We therefore suggest that increasing emphasis be put upon this phase of the program especially as it relates to the general practitioners.

Respectfully submitted, Ralph McReynolds, M.D., Chairman, Karl Vehe, M.D., C. Paul White, M.D., Harry J. Dooley, M.D.

(DR. MC REYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. Oscar Hawkinson, Chicago, and carried).

*Reference Committee on Advisory Committee to the Woman's Auxiliary*: The Advisory Committee to the Woman's Auxiliary Committee has made the following supplementary report: All the officers of the Auxiliary have attended the speaker's training course, and as a result they are anxious to join in supporting you in a fight against socialized medicine, and ask to be guided in that aid. This is in addition to their activities already carried on such as the support of the Benevolence Committee to which they have contributed $5,354 the past year. They have promoted the sales of "Today's Health", formerly "Hygeia" to the extent of 560 subscriptions. They have been active in collecting historical data for the Society.

We recognize the important part that the Woman's Auxiliary has taken in furthering the program of the State Medical Society as regards compulsory health insurance. We further recognize the Auxiliary as a most valuable asset in public relations. We wish to thank them and to commend them for their contributions to the Benevolence Fund and for their attendance at state meetings and for their services in assisting in the collection of historical data. We likewise recognize that the Auxiliary can be an important factor in encouraging physicians to attend their several meetings and suggest that they give more attention to this fact in the raising of their future program.

Respectfully submitted, Ralph McReynolds, M.D., Chairman, Karl Vehe, M.D., C. Paul White, M.D., Harry J. Dooley, M.D.

(DR. MC REYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. L. J. Hughes, Elgin, and carried).

DR. MC REYNOLDS: I move the adoption of the report as a whole. Motion seconded by Dr. E. E. Davis and carried.

THE PRESIDENT: The next report will be from the Committee on Miscellaneous Business, to be given by Dr. M. M. Hoeltgen.

*Report of the Reference Committee on Miscellaneous Business*:

1. *Report of the Chairman of the Advisory Committee, State Commission on the Chronically Ill.*

The work of this committee is highly commended. In the past this committee helped prepare an excellent report to the state legislature. We note that this committee is ready to function in the event that any legislation regarding the chronically ill is introduced in the State Legislature.

(DR. HOELTGEN: I move the adoption of this portion of the report. Motion seconded by Dr. J. H. Hutton, Chicago, and carried).

2. *Report of the Committee on Medical History*:

This committee has presented an excellent report. They are to be congratulated on the progress that they have made. The committee feels that this work should be carried to completion.

(DR. HOELTGEN: I move the adoption of this portion of the report. Motion seconded by Dr. J. H. Hutton, and carried).

3. *Report of the Committee on Nutrition*:

In reviewing this report it is noted that the committee feels that if this subject is of sufficient interest that a paper should be presented at the annual meeting. If this is the case, it is suggested that consideration to be given to having a paper on nutrition read at the General Assembly of the 1951 meeting.

(DR. HOELTGEN: I move the adoption of this portion of the report. Seconded by Dr. J. H. Hutton and carried).

4. *Report of the A. M. A. Delegates*:

This committee commends this pioneer report on the multitudinous affairs transacted by the House of Delegates of the A. M. A. We realize that it is very difficult to make a brief report.

We noted the revision of the principles of medical ethics, the resolution that would make hospital facilities available to general practitioners, and the formation of a committee to study the intern problem.

It is hoped that these reports will continue in the future and that items of particular interest to doctors in Illinois will be commented upon fully.

We noted with pride that Dr. Andy Hall of Mount Vernon won the General Practitioner's Award.

(DR. HOELTGEN: I move the adoption of this portion of the report. Seconded by Dr. Harold Miller, Chicago).

DR. CHARLES H. PHIFER, Chicago: I want to compliment the Committee on the report, particularly the last part. I would like to discuss the question of printing this report in the Handbook. Personally, I feel that when Dr. Bornemeier asked Dr. Greening to make a motion in the House of Delegates that this report be published in the Handbook he had every good intention. There are some disadvantages. The annual meeting last June is now reported in May, eleven months after. Long before this the Journal of the A.M.A. gave a resumé of the proceedings of the House of Delegates. I question the advisability of printing this in the Handbook. I think it would be much wiser if the transactions of the House of Delegates were published much earlier, say in a month or two after the meeting of the House. I would like to see that changed. I would like to hear Dr. Hamilton or any of the other delegates discuss it.

DR. EDWIN S. HAMILTON, Kankakee: I was quite surprised to hear the last day or two that there were several men who did not know anything about what was going on at the A.M.A. and this was the first information they had by reading in the Handbook of what the House of Delegates of the A.M.A. did. I called to your attention that a detailed report

of the activities of the House of Delegates of the A.M.A. appears in the Journal of the A.M.A. immediately after the annual meeting. I take it for granted that most of you men take the Journal. If you are interested in what goes on, if you will take a little time or your wife will take time to read it to you you will get a resumé of what goes on on the floor of the House. I agree with Dr. Phifer that if the resumé was made available by the House of Delegates and presented to the editors within thirty days after both the regular meeting and the interim meeting then the editor could make a short resumé and publish it in the State Journal and anyone who was interested could get the detailed report from the Journal of the A.M.A. Those who were really interested would know within two months after the meeting occurred what had gone on. I think that would be much better than publishing it in the Handbook a year later

DR. WALTER BORNEMEIER: Last year at this corresponding session of the House of Delegates this motion was introduced with the understanding that the reports which are given in the Journal of the A.M.A. and the report that your Secretary of the Illinois State Medical Society makes in the Illinois Medical Journal might be supplemented by some facts that were particularly pertinent to the House of Delegates and to the doctors of Illinois and these might come directly from the House of Delegates. At the moment we get no report directly from our delegates to the A.M.A. unless this report is published. By the same token that we have in this Handbook reports of the Councilors and reports of Committees, this is a resumé that may be kept and placed on file. I think it is a very good thing for us who send delegates to the A.M.A. to require from them a brief report of the activities conducted by the delegates from the State of Illinois to the A.M.A.

THE PRESIDENT: There is a motion that that portion of the report be adopted and it has been seconded.

DR. PHIFER: The question before the House is the adoption of Dr. Hoeltgen's report.

THE PRESIDENT: That is correct. The Chairman moves that that portion of the report be adopted and it carries with it the approval of having the report of the A.M.A. House of Delegates published in the Handbook. (Motion carried).

DR. HOELTGEN: The report is signed: V. B. Adams, M.D., Walter Baer, M.D., M. M. Hoeltgen, M.D., Arthur Taylor, M.D. I move the adoption of the report as a whole. (Motion seconded by Dr. Harold Miller, Chicago, and carried).

THE PRESIDENT: The next report will be from the Resolutions Committee. It has been suggested that the Chairman digest the resolution thoroughly and only read the important part. The report will be presented by Dr. Pliny Blodgett.

*Resolution of Appreciation to the Illinois State Medical Society From the Woman's Auxiliary.*

*Whereas,* The Advisory Committee to the Woman's Auxiliary, appointed by the Illinois State Medical Society, has been most understanding of Auxiliary needs and has constantly encouraged and advised the Board of Directors in all Auxiliary undertakings; and

*Whereas,* The Illinois Medical Journal has continued to give a generous amount of space in its columns for the publication of Auxiliary activities; and

*Whereas,* The Illinois State Medical Society has given much financial aid to the Woman's Auxiliary, having contributed a substantial sum of money for Convention expenses and having printed, free of charge, both the official stationery and the membership roster of the Auxiliary; therefore, be it

*Resolved,* That the Woman's Auxiliary to the Illinois State Medical Society, in Convention assembled, May 23, 1950, express its deep appreciation and sincere thanks to the Medical Society for the assistance which has enabled the Woman's Auxiliary to carry on its work successfully during the past year; and be it further

*Resolved,* That a copy of this resolution be sent to the Advisory Committee to be presented to the House of Delegates of the Illinois State Medical Society during its 1950 annual session.

DR. BLODGETT: No action is necessary on this resolution, it is passed on to the House for its information.

*Reaffirmation of the Principles of the So-Called Hess Report.*

(See page 85 of the First Session of the House of Delegates, July issue of I.M.J.)

DR. BLODGETT: I move the adoption of the resolution. (Motion seconded by Dr. F. Lee Stone, Chicago).

DR. E. S. HAMILTON, Kankakee: I do not know what the resolution is about.

DR. BLODGETT: I will be very happy to read it.

(Reads resolution)

This Committee recommends that it be adopted and I so move. (Motion seconded by Dr. E. H. Weld, Rockford).

DR. HAMILTON: I wish to thank Dr. Blodgett for his explanation. I hope it is very clear to all of you. Personally I know exactly what he is talking about. This is the Hess report having to do with the practice of medicine by hospitals. It is a very controversial question and I am wholly in accord with the recommendations of the Committee. I feel it should be approved. I regret that it was necessary to have it re-read. It will have to do with many of you who are on hospital staffs. I think our delegates should take a very active part in it. I have been on the Hess Committee for two or three years. It will be a fine thing for the members of our House of Delegates to read this report and express their opinion. Any of you who have opinions on the practice of medicine by hospitals had better get in touch with the delegates from the State to the A.M.A.

(Motion carried).

*Change In Name for Section on Public Health and Hygiene.*

(See pages 88, 89, 90, first session of House of Delegates in July issue).

DR. BLODGETT: There were several resolutions on this same subject. The Committee finds no objection to such a change and therefore recommends its adoption. I so move. (Motion seconded by Dr. Harold Miller, Chicago, and carried).

*Compulsory Health Insurance.*

(See pages 86, 89, and 90 of the First Session)

DR. BLODGETT: Several resolutions voicing our opposition to Compulsory Health Insurance were presented and the Committee presents the following from the Central Illinois Pediatric Society and from the National Association of Medical-Dental Bureaus, Inc. The last resolution has been changed to apply to the Illinois State Medical Society and the last portion of it will read as follows:

*Be It Resolved,* That the Illinois State Medical Society meeting in its annual convention in Springfield, Illinois, May 25, 1950, does hereby go on record against any form of compulsory health insurance or any system of political medicine inevitably resulting in bureaucratic control; and

That a copy of this Resolution be forwarded to the President of the United States, to each Senator and Representative now in the Congress of the United States from the state of Illinois, and that said Senators and Representatives be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

DR. BLODGETT: I move the adoption of these resolutions. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

*Clearance from the Educational Committee on Talks Concerning Health and Medical Care to be Given on Radio or Television Programs.*

(See page 88 of the First Session)

DR. BLODGETT: The Committee recommends the adoption of this resolution and I so move. (Motion seconded by Dr. Charles Allison, Kankakee, and carried).

*Prosecution of Non-Licensed Practitioners.*

(See Page 85, First Session)

DR. BLODGETT: Your Committee recommends that the Department of Education and Registration of the State of Illinois be commended for their efforts in curbing the activities of illegal practitioners of the Healing Arts, and we urge that the department redouble its efforts in enforcing the law in this regard. I move the adoption of that resolution. (Motion seconded by Dr. Robert H. Hayes and carried).

*Examination of Pre-School Child.*

*Whereas,* the State Health Law of 1944 requires that each school child be given a physical examination at the begining of his school life and each four years thereafter, and

*Whereas,* there is no penalty or appropriation provided by this law, and

*Whereas,* in the last six years only sporadic and widely separated local programs have been undertaken, without coordination or unified effort, and

*Whereas,* examinations such as are required by this law are of vital importance to a child's health and education,

*Now, Therefore, Be It Resolved:* That the House of Delegates of the Illinois State Medical Society urges all component county medical societies, in conjunction with existing agencies in their localities, to sponsor and develop the necessary programs to the end that a coordinated statewide compliance with the law be achieved.

DR. BLODGETT: The Committee recommends that this resolution be adopted and I so move. (Motion seconded by Dr. E. H. Weld and carried).

*Resolution Petitioning for a Change in the Constitution and By-Laws of the A.M.A. for the Seating of newly Elected Delegates and the Alternates 60 days after their Election.*

*Whereas,* the Constitution and By-Laws of the A. M.A. now provides that newly elected delegates may not assume office until January 1 following their election and

*Whereas,* this can and sometimes does cause an elected delegate to be delayed for two meetings of A.M.A. before assuming the duties of his office, therefore

*Be It Resolved* that Chapter 9, Section 1, Paragraph B of the Constitution and By-Laws of the A.M.A. be changed to provide for the induction into office of newly elected delegates sixty days after election.

DR. BLODGETT: The Committee recommends the adoption of this resolution. (Motion seconded by Dr. Oscar Hawkinson, Chicago, and carried).

*Resolutions Requesting Seperate Sections on Diseases of the Chest and Allergy.*

(See page 89 of First Session)

DR. BLODGETT: Your Committee is of the opinion that new Sections be not established at this time. We are of the opinion that the subjects are of sufficient importance so that pertinent articles on their subjects should be presented on the general program, and that the Program Committee at our next annual meeting allow for such presentation. I move that the resolutions be not approved. (Motion seconded by Dr. G. E. Johnson, Chicago, and carried).

DR. BLODGETT: Several resolutions were presented relative to the Regulations and Payments made by the Illinois Public Aid Commission and were carefully reviewed.

(See pages 86, and 88 of the First Session)

Since these resolutions were written the Illinois Public Aid Commission has rescinded its action requiring prior authorization for hospitalization of the recipients of Public Aid and has now placed it back on the County level, which was the complaint in the resolutions and which was also voiced by all others who appeared before the Commission. There were also complaints relative to the allowance for drugs and biologicals which in many instances have been below cost to the practitioner.

Your Committee feels that the Illinois Public Aid

Commission should be commended for its retraction of the prior authorization for hospitalization directive and your Committee urges that the Medical Advisory Committee meet with the Illinois Public Aid Commission to properly adjust the payment allowed for drugs and other changes or allowances. I move the adoption of that portion of the report. (Motion seconded by Dr. Harold Miller, Chicago and carried).

*The Fixing of Fees in our Dealings with Labor Unions and Other Groups.*

(See page 86 of the First Session)

DR. BLODGETT: The Committee is of the opinion that this should be handled on a local level under the guidance of an Advisory Committee of the State Society. I move the adoption of that portion of the report. (Motion seconded by Dr. Charles Allison, Kankakee and carried).

*Physicians Employed on a Full-Time Basis in State Institutions should Refrain from the Private Practice of Medicine*

(See page 87 of the First Session)

DR. BLODGETT: Your Committee has given this considerable thought.

The subject is broader than appears in the resolution presented to us, and is a problem which goes into the Federal government personnel, veterans administration, the public health service, in the medical activities of the Army, Navy, and Air Corps, as well as fulltime medical officers in county and city government as well as in many quasi government institutions.

Your Committee therefore recommends that the Council of the Ilinois State Medical Society designate a committee, to study the infringement upon private practice by full time physicians on public payrolls, and that the House of Delegates be given a report at our next annual meeting.

In this connection this Committee realizes that in some instances throughout the state there has been a problem created by full-time physicians in public institutions who have been actively engaged in private practice.

We recommend that where these instances occur which tend to disrupt private practice in the community that the case, or cases, be adjudicated by the Illinois State Medical Society with the Department of Public Welfare.

DR. BLODGETT: I move that this resolution be referred to the Council. (Motion seconded by Dr. E. H. Weld and carried).

*Diabetes Detection Drive of the American Diabetes Association*

(See page 89 of the First Session)

DR. BLODGETT: This is a resolution to encourage the laity to run their own urine analyses and to make their own diagnoses. Your Committee is of the opinion that self-diagnosis by the laity is a dangerous thing and does not belong in the field of scientific medicine. We, therefore, recommend that this resolution be not adopted. (Motion seconded by Dr. Oscar Hawkinson and carried).

*Medical Benevolence Fund*

(See page 87 of the First Session)

DR. BLODGETT: Your Committee recommends that no change be made at this time relative to the allocation of a portion of our dues into this fund. Your Committee recommends that this resolution be not adopted. (Motion seconded by Dr. Oscar Hawkinson and carried).

*Disapproval of the Method of Collecting A.M.A. Dues*

(See page 85 of the First Session)

DR. BLODGETT: Your Committee recommends that this resolution be not adopted. (Motion seconded by Dr. L. J. Hughes, Elgin and carried).

DR. BLODGETT: These reports are signed by Drs. Bernard Klein, Willard W. Fullerton, Harold Miller and Pliny Blodgett. I move the adoption of the report as a whole. (Motion seconded by Dr. Charles Allison and carried).

DR. E. S. HAMILTON, Kankakee: With your indulgence I would like to make two statements concerning the yearly dues for the American Medical Association. In the first place the resolution says the American Medical Association requested that each state medical society assume the responsibility for collecting the $25 yearly dues and that the American Medical Association allegedly made the above request because of lack of administrative personnel and insufficient planning to handle the collection. That statement is not correct. The reason that the dues are being collected through the state societies is because the state society is the only one that has a complete authentic list of its members. In the American Medical Association as in any other organization you have to collect the dues at the cross roads rather than from the top down. It was not done on that account.

Second, that membership in the A.M.A. is mandatory for membership in the County and State Medical Societies. That statement is untrue. In the first place the A.M.A. is a federation of state societies. The A.M.A. can not tell the Illinois State Medical Society who it can take in for members and who it can not, now or at any time. A man can belong to the Kankakee County Medical Society and to the Illinois State Medical Society under the present Constitution and By-laws of the Kankakee County Medical Society and the Illinois State Medical Society and not be a member of the A.M.A. I understand that a member from the Committee on Constitution and By-Laws is going to make a speech. I do not know whether I could make that statement ten minutes from now. If I can not it is because you gentlemen say so. You gentlemen run the Illinois Medical Society and not anybody connected with the A.M.A. Those are two things I want to tell you and I do not want you to ever forget them because they are both pretty important.

THE PRESIDENT: We now come to unfinished business.

DR. WARREN FUREY: I am acting in accordance with the recommendations of the Reference Committee on the Constitution and By-laws amend-

ment. We were asked to consider the qualifications for membership. I would like to offer an amendment to Article 3 of the Constitution by adding: Members of component societies shall be members of this organization and of the American Medical Association. I move the adoption of this section. (Motion seconded by Dr. P. R. Blodgett, Chicago Heights and carried).

I would like to amend Article 10 of the Constitution by adding to the end of paragraph 1: Such assessment shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. I move its adoption. (Motion seconded by Dr. Harold Miller, Chicago and carried).

I should like to amend Chapter 11, Section 1 of the By-laws by adding: , and members thereof shall be members of this Society and of the American Medical Association. I move the adoption of this amendment. (Motion seconded by Dr. Harold Miller and carried).

The second portion of the report of the Constitution and By-laws Committee has to do with the setting up of a Grievance Committee. I move to amend Chapter 9, Section 1 of the By-laws by adding: A Grievance Committee. (Motion seconded by Dr. W. E. Kittler and carried).

I move to amend Chapter 9 by adding a Section VIII, as printed on page 57 of the Handbook. (Motion second by Dr. W. E. Kittler and carried).

The other matter does not appear in the Handbook. I move that we amend Chapter 2 of the By-laws to correspond to the By-laws of the A.M.A. with reference to active members delinquent in the payment of dues. (Motion seconded by Dr. W. E. Kittler and carried).

I move the adoption of the report as a whole. (Motion seconded by Dr. Harold Miller, Chicago and carried).

DR. HARLAN ENGLISH: The House of Delegates has just amended the By-laws to establish a Grievance Committee. The method of election seems to be not designated. It should be activated in some manner. Why wait a year? There are six members to be elected according to the By-Laws. Could this be submitted to your consideration? Why not take the six past presidents and let them draw by lot the order in which they are to serve for 1, 2 or 3 years. I will so move. (Motion seconded by Dr. E. S. Hamilton and carried).

DR. OSCAR HAWKINSON, Chicago: Will the group indicate how the Chairman shall be elected?

THE PRESIDENT: The Committee will select their own Chairman and the term of office.

THE PRESIDENT: The Secretary has some communications to read.

THE SECRETARY: I have a letter that came in early in the year from an old member of this Society. The letter is from Dr. Frank M. Dry of Chicago and read: "I am contemplating leaving the city for a period of two years. I have been a member for many years. I would ask your permission for a leave covering this period. My work will be with the Armed Forces in the Far East doing hospital work."

I have been told if this permission is granted we will have about 200 other requests for the same action. I wrote to him that this matter would be referred to the House of Delegates.

DR. WARREN FUREY, Chicago: I think most of us are in accord with the statement of the Secretary, that it would be a bad policy to establish. I move that we do not remit the dues of Dr. Dry. (Motion seconded by Dr. E. S. Hamilton, Kankakee and carried).

THE SECRETARY: I have one thing that I would like permission of the House on. Each year at the close of the second session of the House of Delegates we have been instructed by the House to officially thank the many people who have been responsible for making the arrangements and doing everything toward making the meeting a success. In this instance it includes the Chamber of Commerce of Springfield, the hotels, the Sangamon County Medical Society and the many people in and around Springfield that did such fine work.

DR. W. W. FULLERTON, Steelville: I so move. (Motion seconded by Dr. E. H. Weld of Rockford and carried).

THE PRESIDENT: We now come to the election of Emeritus members.

THE SECRETARY: I have the following applications for Emeritus membership and for past service membership:

*Emeritus Membership*:

Chicago Medical Society:

Leslie W. Beebe, 401 Forest Ave., Oak Park
Arthur R. Elliott, 1120 Lake Shore Dr., Chicago
A. A. Goldsmith, 5724 Kimbark Ave., Chicago
Armina S. Hill, 3027 Washington Blvd., Chicago
Peter J. Latz, 4920½ W. Quincy Ave., Chicago
Alfred Lewy, 2051 E. 72nd Place, Chicago
Adolph M. Magnus, 7743 N. Paulina St., Chicago
George M. McBean, 6935 Chappel Ave., Chicago
John J. Pflock, 844 Houseman St., LaCanada, Calif.
Arthur G. Schroeder, 1430 Belleplaine Ave., Chicago
F. H. Stevenson, 9904 Ewing Ave., Chicago
A. M. Stober, 2445 N. Kedzie Blvd., Chicago
Adam L. Yuska, 2422 W. Marquette Rd., Chicago
W. A. Newman Dorland, c/o A. J. Hoffman, 11880 N.W. 7th Ave., North Miami, Fla.
Frank B. Knudson, 4825 Oakdale Ave., Chicago
Gustav H. Moldenhauer, 853 N. Central Ave., Chicago
Edwin W. Ryerson, 232 E. Walton Place, Chicago
Robert H. Buck, 312 Cardinal Ave., San Antonio, Texas
Julius F. Meyer, 1039 Hollywood Ave., Chicago
O. T. Roberg, Sr., 2006 Irving Park Road, Chicago
Carl O. Schneider, 1077 Cherry St., Winnetka
David L. Schram, 5242 Hyde Park Blvd., Chicago

*County*

Adams, William Zimmermann, Quincy
Boone, John H. Brantley, La Jolla, California
Bureau, Sandor Horwitz, Peoria

Christian, Thomas A. Lawler, Taylorville
Crawford, Levi R. Illyes, Palestine
Effingham, Frank Buckmaster, Effingham
Elbert L. Damron, Effingham
Samuel C. Lorton, Shumway
D. H. Taphorn, Effingham
Henry, Charles A. Coffin, Kewanee
JoDaviess, Ulysses S. Lewis, East Dubuque
Coleman G. Buford, Elizabeth
Kane, George A. Darner, Aurora
La Salle, John F. Lewis, La Salle
Madison, Moses W. Harrison, Collinsville
Morgan, Edwin W. Crum, Waverly
Peoria, Roland L. Green, Peoria
A. S. Plummer, Peoria
Richland, A. T. Telford, Olney
Sangamon, Charles L. Patton, Springfield
Whiteside, Stephen A. Allen, Rock Falls
Frank W. Brodrick, Sterling
Walter I. Carolus, Sterling
Clarence M. Frye, Sterling
William H. Perry, Sterling

*Past Service Membership*:

Chicago Medical Society:
Alexander Baron, 601 S. 4th St., Champaign
Jesse W. Carr, 52 Chicago Ave., Clarendon Hills
Bowman C. Crowell, 105 E. Delaware Pl., Chicago
R. J. DeMotte, 500 W. 118th St., Chicago
Irwin P. Fovrague, 415 N. Tucson Blvd., Tucson, Ariz.
George E. Mueller, 1315 W. Beach Pl., Biloxi, Miss.
Henry S. Sherman, 5015 Quincy St., Chicago
Harry E. Walsh, 8057 S. Marshfield Ave., Chicago
Alice Conklin, 104 Parsonage, Dowagiac, Mich.
Clara M. Davis, 550 Oak St., Winnetka
Allen J. Miller, 5341 S. Paulina St., Chicago
Abraham S. Park, Campos Elisos 339, Mexico City, D.F. Mexico
Robert Reich, 558 W. 119th St., Chicago
Ida Ruth Gorov, R.F.D. No. 1, Roselle, Ill.
Harold E. Jones, 421 Melrose St., Chicago
Thomas G. Jones, 1300 W. 64th St., Chicago
Charles E. Kahlke, P. O. Box 375, Benton Harbor, Mich.
Eugenia A. Miller, 2130 Lincoln Park West, Chicago
Wilhelmina Slapak, 1429 Warwick Ave., Whiting, Ind.

*County*

Champaign, Henry Quastler, Urbana
Christian, George A. Tankersley, Taylorville
Franklin, W. W. Sheerer, Christopher
Logan, W. W. Coleman, Lincoln
McLean, Frederick P. Goodwin, Bloomington

DR. E. S. HAMILTON: I move that these be elected to Emeritus and Past Service Membership. (Motion seconded by Dr. L. J. Hughes, Elgin and carried).

THE PRESIDENT: Is there any other new business?

DR. W. E. KITTLER, Rochelle: I would like to make the suggestion that our Secretary be instructed to make reservations for delegates who attend this meeting and for officers. I understand when you go to the A.M.A. that is done.

THE SECRETARY: We have been aware since last January of the fact that we had a limited number of rooms in Springfield. We put a form sheet in the Illinois Medical Journal and all you had to do was to fill it out and sent it in order to get your hotel reservation. If we made the reservations the hotel would have to write to each one individually. It would be much better if the delegate filled out the slip and sent it in.

THE PRESIDENT: It now becomes my very pleasant duty to introduce to you the new President, Dr. Harry Hedge. I will ask Dr. C. Paul White to conduct Dr. Hedge to the Chair.

Dr. Hedge, it is a great pleasure to conduct you into office as President of this great Society. I turn over this gavel to you and you are now the President.

DR. HEDGE: I do not care to take too much of your time but I have just a few things that I would like to say.

It is with great humility that I accept this gavel and as my fingers encompass its handle, which has been held by those whose lives have lent prestige to this high office for so many years in Illinois, I feel that before me they stand, not visible but never-theless present, and to them as well as to you I owe a great accounting.

In selecting my profession, many opportunities presented: a. Newspaper; b. Commercial and illustration photography; c. That great profession of *teaching;* d. The altrusism of Y.M.C.A.; e. The financial lure of *business.* Then along comes a great and sympathetic surgeon who deftly moulded one of my mangled fingers into a usable member after it had accidentally passed through the closely meshed cogwheels of a printing press. He cast the die and my future lay in the path of medicine.

The boy whose parents were concerned about his choice for the future — a. A Bible-Minister; b. A Book-Lawyer; c. A silver dollar-banker; d. A sandwich, — a business purveyor of commodities. He put the Bible under his left arm, the book under his right, put the dollar in his pocket and ate the sandwich. They said he will be a politician.

I wrote my article for the newspapers. I photographed my interesting cases, I tanght in a medical school, I organized a basket ball team to play at the "Y" and took up medicine to make a living.

A Committee for a fund drive. A Committee for a health program. A Committee for improvement of the educational program. But when there is lying a body bruised and bleeding who is dear to someone they say get a physician quick and if by staunching the flow of blood, by easing the respiration, and fortifying the heart muscle, the sufferer is returned to health and usefulness, all are happy.

But should the physician be ushered into a blood splattered room by a big, strong, fine appearing boy with tears streaming down his manly face, and he says,

"Doc, do all you can for Dad," and the case is recognized as that terrible, terminal stage of a lung malignancy we do what we can and if we are big enough we may scrub up some of the unsightliness and act as the great mediator between the present and that great unknown and thus convey peace to troubled hearts. We did what we could and beyond the call of duty.

My all is at your command, and the will of over 10,000 physicians is no light responsibility but I accept it.

When one of our great Pediatricians was being inducted into the Presidency of the A.M.A. he was introduced as such, but he quickly corrected his introducer and said, "Gentlemen I am a physician."

Your help and your cooperation are needed. Your good wishes have already been expressed. I know I have both, and for the next twelve months we will work for those highest ideals in medicine which will make the socialization of medicine by government agencies, with all of its heated discussions, fall as Wm. Jennings Bryan said, "Into a state of Permanent innocuous desuetude."

THE PRESIDENT: Is there any other business to come before the House?

DR. E. S. HAMILTON, Kankakee: I move we adjourn. (Motion seconded by Dr. Robert Hayes and carried).

The House of Delegates adjourned sine die at 1:15 P. M.

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## PHYSICAL MEDICINE IN THE VETERANS ADMINISTRATION (Continued)

cord lesions and other neurological conditions, the blinded, the deaf, amputees, those with tuberculosis, head injuries, psychiatric disorders, those with arthritis and severe orthopedic conditions, etc., present the major problems in rehabilitation. The solution of this problem of rehabilitation taxes to the very maximum the ingenuity and skill of all of us in this ever-expanding field in medicine, the specialty of physical medicine and rehabilitation.

There is no final word, no routine procedures, nor have any final answers been given to any of the problems in Rehabilitation. There is no single technic, either in diagnosis or treatment that cannot be improved upon. Research and investigation is a never-ending process and must go hand-in-hand and be an inseperable part of successful total rehabilitation.

As part of an in-service training program, two courses of instruction in physical medicine and rehabilitation were given at the Veterans Administration Hospital, Hines, for VA physicians. Short courses of instruction were also given at Hines for various groups of VA therapists.

Rehabilitation must be a dynamic, moving, forceful, ever-changing program and we, the doctors, must have vision and keep our minds open for new ideas and continually seek for more effective methods of diagnosis and treatment in order to attain the goal of maximum usefulness for the disabled.

Physical medicine and rehabilitation has changed the future of the disabled veteran from one of darkness and hopelessness to one of hope, life and satisfaction. What could be more worthwhile.

# NEWS OF THE STATE



## CHAMPAIGN

**Society News.**—Dr. Edward Rosenberg, director of the arthritis clinic, Michael Reese Hospital, Chicago, addressed the Champaign County Medical Society recently on "Management of Arthritis From the Standpoint of the General Practitioner."

## COOK

**Dr. Fitz Named to New Post.**—Dr. Frederick W. Fitz, assistant professor of medicine, Northwestern University Medical School, was recently named president of the medical staff at Passavant Memorial Hospital. He succeeds Dr. John F. Delph.

**Dr. Kretschmer Honored.**—At the recent meeting of the American Association of Genito-Urinary Surgeons, in Hershey, Pa., the Keyes Memorial Medal was presented to Dr. Herman L. Kretschmer. This award was established in memory of Dr. E. L. Keyes, Sr., who was an outstanding urologist of his day, as well as teacher, author, and founder of the Association. The award was given to Dr. Kretschmer in recognition of his outstanding contributions to urology.

**Society News.**—Dr. John B. O'Donoghue will address the National Gastro-Enterological Society in New York, October 8, 1950, on "Surgical Treatment of Ruptured Gastric and Duodenal Ulcer and Their Complications."

**Students and Faculty Guests of Eli Lilly.**—Students and members of the faculty of the University of Illinois College of Medicine were guests of Eli Lilly in Indianapolis, June 7-9. The trip included an inspection of the laboratories in Indianapolis and the biological laboratories at Greenfield, where demonstrations were made showing production of biological products.

**Hektoen Lecture.**—Jesse E. Edwards, assistant professor of pathologic anatomy, Mayo Foundation, University of Minnesota, gave the twenty-sixth Ludvig Hektoen Lecture of the Frank Billings Foundation of the Institute of Medicine recently. The title of his presentation was "Structural Changes of the Pulmonary Vascular Bed and Their Functional Significance in Congenital Cardiac Disease."

**Special Society Elections.**—At a recent meeting of the Illinois Psychiatric Society in Chicago, the following officers were chosen: Dr. D. Louis Steinberg, president; Dr. William H. Haines, vice president; Dr. Leo A. Kaplan, secretary-treasurer; Dr. V. G. Urse and Dr. Charlotte G. Babcock, councilors.—The officers of the Chicago Roentgen Society for the year 1951 were elected as follows: Dr. John H. Gilmore, president; Dr. Frank L. Hussey, vice president; and Dr. Benjamin D. Braun, secretary.—The Chicago Orthopedic Society elected Dr. Manley A. Page as president for the year 1950-1951. Other officers are Dr. Ferdinand Seidler, president-elect; Dr. Joseph David Farrington, vice president; Dr. Sam W. Banks, secretary-treasurer and Dr. William J. Schnute, assistant secretary.—Dr. Townsend B. Friedman was recently elected president of the Chicago Society of Allergy, Dr. Theron G. Randolph, president-elect and Dr. Milton M. Mosko, secretary-treasurer.—The Chicago Pediatric Society has elected the following officers for the year 1950-1951: Dr. Alvah L. Newcomb, president; Dr. Craig D. Butler, vice president; Dr. Maxwell P. Borovsky, treasurer; Dr. Alfred S.

Traisman, secretary; and Dr. Matthew M. Steiner, editor.

**Polio Research.**—Two March of Dimes grants totaling $17,234 have been awarded to Northwestern University for polio research, it was announced recently by Basil O'Connor, president, National Foundation for Infantile Paralysis, and Dr. J. Roscoe Miller, President of Northwestern. One grant of $8,000 will enable scientists under the direction of Dr. Lewis J. Pollock, professor of nervous and mental diseases, to complete their studies of the sequence of changes in nerve and muscle tissues affected by polio. The second grant, $9,234 will be for basic and postgraduate instruction in physical therapy under the direction of Dr. Stafford L. Osborne, chairman, department of physical medicine.

**Nathan Goldblatt Memorial Hospital Dedicated.**—On June 15, dedicatory ceremonies were held for the new Nathan Goldblatt Memorial Hospital for the University of Chicago. Among the speakers were Chancellor Robert M. Hutchins, President Ernest Cadman Colewell, Clarence Cook Little, Sc. D., director of the Jackson Memorial Laboratories, Bar Harbor, Maine. A special scientific session was held as part of the ceremony which was presided over by Dr. Lowell T. Coggeshall, dean of the division of biological sciences at the University, with the following speakers: Dr. W. U. Gardner, New Haven, Conn., on "Hormonal Imbalance and Experimental Tumorigenesis"; Linus Pauling, protein authority and professor of chemistry, California Institute of Technology, "Molecules—Our Friends and Enemies" and C. H. Li, associate professor, Institute for Experimental Biology of the University of California, who was the first to describe a method to isolate ACTH from the hog pituitary gland, "Hormones of the Adrenal Cortex." The hospital, initiated in 1946 with a million-dollar gift from the Goldblatt Brothers Foundation, was erected at a cost of $2,200,000. Almost half of the seven-story building is devoted to laboratories, patient facilities and also part of the research program.

**Music With Anethesia.**—The University of Chicago has arranged a hook-up for recorded music in its six major operating rooms and six preparation rooms, it was recently announced. "Music for surgery," as the anesthesia procedure is vernacularly called in the clinics, is directed by Dr. Lester R. Dragstedt, chairman of the department of surgery, Dr. Huberta M. Livingstone, head of the anesthesia department, and Dr. Geraldine A. Light, assistant professor of anesthesiology. Joel Willard, audio-engineer, made the installation.

First introduced in the University of Chicago Clinics in 1947 as a research experiment to help alleviate tensions of patients undergoing surgery, the music for surgery was so successful a permanent installation was contracted for. The research was financed by a grant from the United States Navy and the installation, by funds raised by Maurice Goldblatt, president of the University of Chicago Cancer Foundation.

Used with spinal, local or regional anesthesia, music is piped to the operating rooms from a central duonetic recorder room, especially designed for the university's medical center by Willard. In the master control room, three duochannel magnetic tape recorders, each with a different type of music, play continuously for four hours.

To the patient who is to have musical serenading with an appendectomy, vagotomy or other operations where general anesthesia is not advisable, the music for surgery lessens the patient's apprehension of the pending operation.

Among the first callers to the patient the night before the operation is the anethesiologist who asks, "Will you have classical, semi-classical, or popular music with your operation tomorrow?"

To the children, he offers music from Cinderella, Peter and the Wolf, Pinnochio or others of the current favorites.

## CRAWFORD

**Society News.**—"Tuberculosis is Preventable" was the title of a talk by Dr. Norman J. Rose, Highland, at a public meeting in Robinson recently.

## HANCOCK

**Personal.**—Dr. R. R. Loomis, Warsaw, recently completed fifty years in the practice of medicine, thirty of which were spent in Warsaw.

## KANE

**Personal.**—Dr. K. G. Bulley, Aurora, was elected president of the Illinois Tuberculosis Association at its recent annual meeting in Springfield.

## MACON

**Health Council Organized.**—Sixty-three interested persons representing various official and voluntary organizations met recently in Decatur to form a health council for Macon County. Dr. Herman Dorn was made chairman of a steering committee, which subsequently decided that a complete survey of all the medical facilities in the county was necessary to determine local problems and obviate overlapping of activity. Dr. P. A. Steele, of the Decatur Health Department, was appointed chairman of the survey committee. Following the completion of the survey, the health council will tackle any specific problems or projects which may arise. The council does not plan to furnish health services itself, but will: Bring together medical, allied professional, and other interested groups for discussions and planning in the health field; Serve as a clearing house on health and medical care problems and programs; Reduce duplication of effort; Survey the needs for additional educational facilities for doctors, nurses and other workers in the health field, and foster plans for obtaining needed facilities; Encourage, stimulate, foster and actively support the establishment of health and medical care programs

designed to improve the health of the people of Decatur and Macon County.

## MONROE

**Public Celebration Honors Physician.**—The entire community of Valmeyer turned out Sunday, June 4, to honor Dr. Roy G. Empson. Over one thousand spectators watched as four hundred of Dr. Empson's "babies" marched in a parade behind the American Legion color guard and the 110-piece Valmeyer High School band. Speakers included Congressman A. A. Brande, Chester, and Dr. Andy Hall, Mount Vernon, "1949 Doctor of the Year." The public demonstration was preceded by a banquet. Gifts to Dr. Empson included a 1950 Plymouth and a matched luggage set. On behalf of the Monroe County Medical Society, Dr. Joseph Werth, Waterloo, president, gave Dr. Empson a medical kit.

## MORGAN

**Physician Honored.**—Dr. E. W. Crum, Waverly, received the insignia of the Fifty Year Club of the Illinois State Medical Society at a recent meeting. Dr. F. Garm Norbury, Jacksonville, Councilor for the District, made the presentation. Dr. A. G. Schultz addressed the meeting on "Diseases of the Eye."

## RICHLAND

**Personal.**—Dr. W. E. Fritschle, Olney, recently observed his fifty-seventh year of the practice of medicine. He has served four times as mayor of Olney as well as having been school treasurer for a number of years.

## ROCK ISLAND

**District Meeting.**—The annual meeting of the Central District Medical Association was held at Jul's Farm, Moline, recently. The speakers were Dr. Philip Thorek, on "The Acute Abdomen" and Dr. Wright Adams, "Diagnosis and Prognosis of Coronary Disease", both of Chicago. The discussers were Dr. Walter E. Foley and Dr. Robert A. Towle, both of Davenport, Iowa.

**Personal.**—Dr. Robinson Bosworth, medical director and superintendent of the Rock Island County Tuberculosis Sanatorium was made a life member of the Illinois Tuberculosis Association recently. He received the membership for the years of service he has given the association.—Dr. F. E. Bollaert, East Moline, city physician for the last five years, has resigned. In his resignation, Dr. Bollaert pointed out that he found it impossible to properly perform his activities under conditions which gave special privileges to certain violators.

## SANGAMON

**Personal.**—Dr. Frank Davis, Springfield, was elected president of the Public Health Nursing and Tuberculosis Association recently.

**Society News.**—Dr. John Brewer, Chicago, recently addressed the Sangamon County Medical Society on "Management of Post-Menopausal Bleeding."

## SHELBY

**Ninty-Five Years of Age.**—Dr. J. C. Westervelt, Shelbyville, observed his ninty-fifth birthday June 7. Dr. Westervelt has been a resident of Shelbyville for eighty years and has been living in his present home for more than sixty-five years. He has been retired since 1943. He served his county not only as city health officer but also as mayor.

## WAYNE

**New Fairfield Hospital.**—Governor Adlai E. Stevenson delivered the principal address at the dedication of the 84-bed Fairfield Memorial Hospital, Fairfield, June 25.

This general hospital, constructed with financial aid from the state and federal governments in the program to provide hospital facilities within access of every Illinois resident, is the fourth to be completed in the current expansion program.

Fairfield Memorial Hospital Association, the state government and the federal government each paid equal shares of the $1,235,174 costs of the hospital.

Dr. Roland R. Cross, director of the state Department of Public Health also took part in the dedicatory ceremonies.

## WINNEBAGO

**Society News.**—Dr. Gershom J. Thompson, head of the department of urology, Mayo Clinic, discussed "Urological Problems" before the Winnebago County Medical Society recently.

**Personal.**—Dr. Robert M. Lewis has been named clinic physician in the city health department of Rockford, succeeding the late Dr. John R. Porter. Dr. Lewis has practiced in Rockford since 1945, specializing in urology.

## GENERAL

**Biological Photographic Association.**—The twentieth anniversary meeting of the Biological Photographic Association will be held at the Hotel Sheraton, Chicago, September 6-7-8. Papers on such subjects as surgical motion picture photography, photomicrography, photography of gross specimens, copying radiographs, stereophotography, legal aspects of patient photography and the preparation of prints for publication will be presented. Physicians interested in the subject of clinical photography are invited to attend. For further information and/or a copy of the preliminary program, write to: Ralph P. Creer, Convention Chairman, Biological Photographic Association, Inc.; Address: American Medical Association, 535 North Dearborn Street, Chicago 10.

**Illinois Heart Association.**—Dr. Edward Cannady, East St. Louis, was recently elected as president of the Illinois Heart Association at its recent annual meeting in Springfield. Other officers elected were Dr. Frank Deneen, Bloomington, vice president;

Dr. Robert Elliott, Alton, secretary and Leonard Hoffman, Springfield, treasurer. Mrs. Margaret Ingram, Springfield, was reelected executive director of the state group.

**American Congress of Physical Medicine.**—The American Congress of Physical Medicine will hold its twenty-eighth annual scientific and clinical session August 28-31 and September 1, 1950 inclusive, at the Hotel Statler, Boston, Massachusetts. Scientific and clinical sessions will be given on the days of August 28-31. and September 1. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific session, the annual instruction seminars will be held August 28-31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2.

**Meeting of Crippled Children and Adults.**—The Annual Convention of the National Society for Crippled Children and Adults will be held October 26-28, at the Stevens Hotel, Chicago, according to Lawrence J. Linck, executive director of the Easter Seal Agency.

Marking 29 years of service for the Society, the convention will feature prominent authorities working in the field of the disabled who will present latest developments in the treatment, training and care for the nation's handicapped children and adults.

An attendance of 5,000 persons is anticipated at the three-day Convention open to the public. Among those of special education, field representatives, board members, parents of crippled children, and others working in the field of the handicapped.

Delegates from the more than 2,000 state and local affiliates of the National Society in the 48 states, District of Columbia, Alaska, Hawaii and Puerto Rico will come to Chicago to obtain up-to-date knowledge of National Society's three-point program of education, research, and direct services.

**Trudeau Society Officers.**—Dr. L. L. Collins, superintendent and medical director of the Madison County Tuberculosis Sanatorium, Edwardsville, was named president-elect of the Illinois Trudeau Society at the society's annual meeting in Springfield recently. Dr. J. T. Maher, Danville, is president.

**Heart Group Chooses Officers.**—Dr. Louis N. Katz, Chicago, was named president-elect of the American Heart Association at the association's annual meeting in San Francisco recently. He will take office at the annual meeting in Atlantic City, June, 1951. Dr. Katz is director of the department of cardiovascular research of Michael Reese Hospital and secretary of the Chicago Heart Association. He was president of the Inter-American Cardiological Congress which met in Chicago two years ago, and is now honorary president of that organization. During the past year he has served as chairman of the research committee of the American Heart Association's Scientific Council. S. DeWitt Clough of Chicago, chairman of the board of governors of the Chicago Heart Association and chairman of the board of Abbott Laboratories, and Dr. Emmet B. Bay, vice president of the Chicago Heart Association and professor of medicine at the University of Chicago School of Medicine, were elected to the board of directors of the American Heart Association at the San Francisco meeting. Dr. Sidney Strauss, Chicago, was elected a delegate-at-large to the association's assembly.

**Medal Awarded for Research.**—Dr. Lester Dragstedt, chairman of the department of surgery, University of Chicago School of Medicine, was awarded the gold medal of the American Medical Association, June 28, at it's annual convention. The research for which the medal was awarded concerned the lower part of the stomach as an organ of internal secretion with potential importance for the treatment of stomach ulcers. This research won the gold medal of the American Medical Association for Dr. Dragstedt and his associates, it was announced June 28 in San Francisco at the annual meeting of the association. This is the fourth time since 1936 that the gold medal has been awarded to University of Chicago investigators. Dr. Charles B. Huggins, professor of urology, won it in 1936 for his studies of bone marrow, and again in 1940 for his work with the sex hormone treatment of cancer of the prostate. Dr. J. Garrott Allen, associate professor of surgery, won the medal in 1948 for an exhibit demonstrating the use of the dye toluidine blue in controlling hemorrhage.

**Gift for Chronic Illness.**—Participating in a concerted national attack on the problems of chronic illness, the National Foundation of Infantile Paralysis has appropriated $5,000 to further the work of the new national Commission on Chronic Illness, it was announced recently by Dr. Morton L. Levin, director of the Commission.

Since 25% of each year's group of polio victims are left with handicaps and must be classified as chronically ill the National Foundation has a vital interest in the work of the Commission, said Basil O'Connor, President of the National Foundation.

"We especially are aware of the need for sound national, state and community planning whereby the needs of this group may be defined and met."

The Commission on Chronic Illness, with headquarters in Chicago, is engaged in an education-research program and represents the first national unified approach to the common problems of the various forms of long-term illness. Other agencies which have pledged financial support in this coop-

erative enterprise are the American Cancer Society, American Heart Association, American Medical Association, National Tuberculosis Association, National Society for Crippled Children and Adults and the New York Foundation.

Dr. Levin reported that a nation-wide survey of present activities and plans in chronic disease control is underway, and a model community survey plan is being developed for use by communities interested in studying their local needs, services and facilities. The plan will be tested in several communities this summer before it is presented for use by communities throughout the country. Plans have also been drawn up for a definitive study of prevalence and medical needs in an urban and a rural area.

## MARRIAGES

James Douglas Stuart to Miss Jeanne Natalie Crane, both of Chicago, May 20.

## DEATHS

Lindsay A. Beaton, Kenilworth, who graduated at Rush Medical College in 1905, died in Janesville, Wis., May 13, aged 70.

Hyman Cohen, Chicago, who graduated at Northwestern University Medical School in 1906, died June 28, aged 73.

Irving Ginsburg, Chicago, who graduated at Chicago Medical School in 1938, died June 6, aged 36.

Earl Vernon Hill, retired, Chicago, who graduated at the University of Illinois College of Medicine in 1904, died May 15, aged 72.

Kenneth P. Hoel, Aurora, who graduated at the University of Wisconsin Medical School in 1929, died while visiting in Battle Creek, Mich., July 4, aged 45.

James Butler Holson, retired, Farlina, who graduated at the Kentucky School of Medicine, Louisville, in 1889, died June 18, aged 86. He was surgeon for the Illinois Central Railroad in Fayette County for 58 years.

Benjamin D. Jenkins, Macomb, who graduated at Northwestern University Medical School in 1895, died June 3, aged 81. He was chairman of the Macomb City Board of Health.

Joseph A. Jerger, retired, Chicago, who graduated at the University of Illinois College of Medicine in 1905, died July 4, aged 69. He was the author of the autobiography, "Doctor Here's Your Hat" published in 1939.

Grace K. Lightfoot, Moline, who graduated at the University of Wisconsin Medical School in 1942, died suddenly, on her way to California, June 12, aged 34.

F. Patrick Machler, Chicago, who graduated at George Washington University School of Medicine, Washington, D. C., in 1910, died June 10, aged 70, at Sacred Heart Sanitarium in Milwaukee. He was a captain in the medical corps in World War I and active in veterans' affairs.

William T. Marrs, Peoria Heights, who graduated at St. Louis College of Physicians and Surgeons in 1894, died June 18, aged 84. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

William C. Masslow, Forest Park, who graduated at Harvey Medical College, Chicago, in 1902, died June 21, aged 83. He was on the staff of Oak Park hospital since its founding, and he was medical superintendent of the German Old Peoples' Home.

John M. Palmer, retired, Waukegan, who graduated at the University of Illinois College of Medicine in 1901, died June 16, aged 80. He was a captain in the medical corps in World War I.

John R. Porter, Rockford, who graduated at Northwestern University Medical School in 1911, died suddenly, March 27, aged 62. He was director of the health center of the city health department, and a past president of the Winnebago County Medical Society.

Alexander J. Prominski, Chicago, who graduated at Chicago College of Medicine and Surgery in 1911, died June 22, aged 61. He had practiced medicine on Chicago's southwest side for nearly 40 years.

Charles E. Riseling, Murphysboro, who graduated at Missouri Medical College, St. Louis, in 1893, died June 23, aged 83.

Italo Frederick Volini, Chicago, who graduated at Rush Medical College in 1917, died while attending the annual meeting of the American Medical Association in California, June 24, aged 57. He was professor and head of the department of medicine of Stritch School of Medicine of Loyola University.

# "FOR THE COMMON GOOD"

*Health Talk on WGN-TV.*—Comments from the mail: "Many thanks again for the part you play in bringing these wonderful TV programs to your listening audience. . . It is my considered opinion that these TV broadcasts are going to be of immeasurable value in getting people to seek proper medical advice—to get a checkup often, so if there is really anything wrong, conditions can be located and further prevented."

"Your programs on television are very educational and understanding. . ."

"We enjoy your television talks and demonstrations more than we can say and hope they will continue indefinitely."

"I've seen your program on television and do wish that you would have something about spastic children on it. I enjoy the program very much."

"Please try to have your program at about 6:30 in the evening so that my husband can see it too. As there is no adult or children's program at that time you should have a good audience. Please do have it on again soon. For whenever you schedule it I won't miss it. It is a wonderful program."

"I've never written to a radio or television program before but must write and tell you how much I enjoy the Health Talk program. I missed it very much when it was off for a short time. It's the most interesting and informative program on television. I especially appreciated the program sometime ago showing operating room procedure. A nurse friend of mine watched it with me and really enjoyed it. I have a seven months old baby so especially enjoyed the program a few months ago showing the mother visiting the pediatrician's office. I really look forward to Health Talk so please keep it on television. It can't be improved upon; it's perfect."

Since the last issue of the Illinois Medical Journal, the following telecasts have been presented:

"Epilepsy" with Paul C. Bucy and John Reynolds, June 26.

"Bronchial Asthma," with Leon Unger, July 10.

Health Talk continues to be telecast over WGN-TV, Mondays, at 3:30 except for days on which baseball games are scheduled.

RADIO

*"Your Doctor Speaks"* over *FM Station WFIL,* Thursday evening, at 7:15, carried the following physicians in transcribed broadcasts:

Claude Lambert, June 29, on Backaches.

Sidney A. Portis, July 6, on Psychosomatic Medicine.

John L. Keeley, July 13, Born with Heart Disease.

George F. Shambaugh, July 20, Deafness.

Leon Unger, July 27, on Allergy.

*"You and Your Baby"* over *Station WAAF,* Tuesday mornings at 10:30 a.m., presented the following physicians in "live" broadcasts:

George Vlasis, July 11, on Prenatal Care.

Charles D. Krause, July 18, on Instructions to the Expectant Mother as Time of Delivery Approaches.

Alvah H. Newcomb, July 25, A Baby Boy is Born.

PRESS

Ann Fox, Secretary of the Educational Committee, won first place in the annual contest of the National Federation of Press Women at its meeting in Reno, Nevada, June 7. The first place award in newspaper or magazine was presented for the Health Talk on "Try Laughing." The Secretary of the Educational Committee had a few weeks earlier won first place in the annual contest of the Illinois Woman's Press Association.

**Committee on Nutrition Publicizes Friends of the Land.**—Dr. G. C. Otrich, Belleville, Chairman of the Committee on Nutrition of the Illinois State Medical Society, in an effort to create goodwill and assist in publicizing the first Chicago meeting of Friends of the Land, established radio and television contacts for Dr. Jonathan Forman, Columbus, and Mr. Louis Bromfield, Mansfield, Ohio, noted author. Through the courtesy of Mr. Paul Visser of NBC, he obtained a "salute" on the National Home and Farm Hour, July 1. With Hal Totten interviewing, WGN-TV cooperated in a newsreel, July 6-7, and Sylvia and Moulton Kelsey of "Coffee with the Kelseys" interviewed Dr. Forman and Mr. Bromfield in their popular broadcast, July 7, over WGN. Vic Barnes of WCFL interviewed Mr. Bromfield Friday evening July 7.

Following the broadcast, James P. Shortall, medical director, Chicago Federation of Labor, and Mrs. Shortall, were hosts to Dr. Forman, Mr. Bromfield, Mr. and Mrs. Edward Condon of Sears Roebuck Company, Mr. and Mrs. Ollie Fink, Columbus, Edith Smith, all of Friends of the Land, Mr. and Mrs. Frank McGivran, of WCFL, and Vic Barnes, studio announcer; Dr. Otrich and Dr. Theodore R. Van Dellen.

In addition to establishing this splendid cooperation, the Committee on Nutrition publicized the meeting through the Illinois Agricultural Association, the PTA, Chicago Chapter, American Red Cross, Chicago Nutrition Association, American Dietetic Association, Chicago Dietetic Association, Illinois Dietetic Association, Evaporated Milk Company, and the Hyde Park Cooperative Society, Inc.

Mrs. Minnie Heim, Chicago Regional Director, PTA, donated her services for the two day session.

The July 6-7 meeting of the Friends of the Land marked the Ninth Annual Institute on Conservation, Nutrition and Health and the first time the session was ever held in Chicago. The theme of the meeting, which was held at the Stevens Hotel, was "Soil, the Cradle of Life."

Dr. Otrich also held a meeting of the Committee on Nutrition of the State Medical Society during the ses-

sion and announced that the 1951 meeting of Friends of the Land would also be held in Chicago.

**Lectures Arranged Through the Scientific Service Committee:**

Martin H. Seifert, Wilmette, Whiteside-Lee County Medical Society in Dixon, July 13, on Early Diagnosis of Poliomyelitis.

Leo P. A. Sweeney, Chicago, La Salle County Medical Society in La Salle, September 14, on Eye Conditions as Seen by the General Practitioner, illustrated.

Louis R. Limarzi, Chicago, Iroquois County Medical Society, in Watseka, September 19, on Management of the More Common Blood Disorders, illustrated.

John B. O'Donoghue, Chicago, Kankakee County Medical Society in Kankakee, September 19, on Surgical Treatment of Gastric and Duodenal Ulcer and Their Complications.

Vernon C. Turner, Evanston, McDonough County Medical Society in Macomb, September 22, on Low Back Pain, illustrated.

John W. Huffman, Chicago, Macoupin-Montgomery County Medical Societies, September 26, on Details and Treatment of Early Carcinoma of the Cervix, illustrated.

## THOUGHTS ON BEHAVIOR

. . . An individual's behavior is dependent upon and determined by all experiences he has had from the time he enters the world until the present moment. Alfred Lord Tennyson expressed this idea perfectly in his work entitled "Ulysses" when he looked back over the span of his entire life and said, "I am a part of all that I have met." Shakespeare also must have had in mind the total personality with all the experiences that make it what it is, when he wrote "All the world's a stage, and all the people in it merely players," and then describes the periods of life from infancy to old age and some of the experiences characteristic of each period. Cervantes in his work "Don Quixote" realized the influence of environment on personality when he wrote:

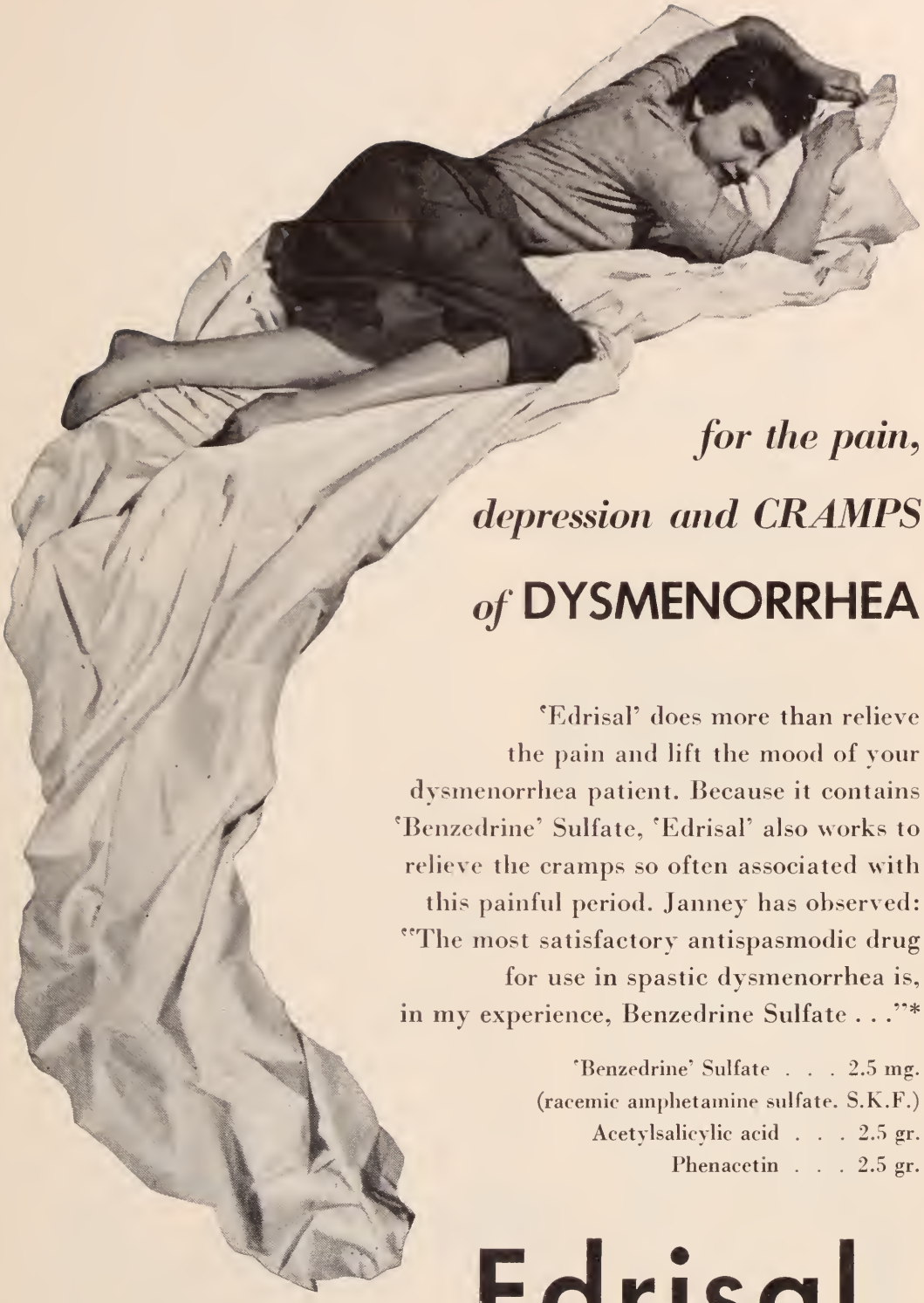
"Show me your company, and I'll show you the kind of person you are." Abraham Lincoln said, "All of us are children of conditions, of circumstances, of environment, of education, of acquired habits, and of heredity, molding men as they are and will forever be." *Excerpt: Psychosomatic Medicine Practicable by the General Practitioner, Luke Ellenburg, M.D., Greeneville, The Journal of the Tennessee State Medical Association, April, 1950.*

## SURGEONS TO MEET IN CLEVELAND

The International College of Surgeons, United States Chapter, will hold its fifteenth Annual Assembly and Convocation in Cleveland, Ohio, October 31, November 1, 2, 3, 1950 according to George M. Curtis, M.D., Columbus, Ohio, Chairman of the Assembly.

All doctors of medicine interested in surgery and its advancement are invited to attend, and can obtain a program upon request to Arnold S. Jackson, M.D., Secretary, Jackson Clinic, Madison 4, Wisconsin. For hotel reservations, contact Committee on Hotels, International College of Surgeons, U. S. Chapter, 511 Terminal Bldg., Cleveland 13, Ohio.

One of the greatest predisposing causes in the spread of tuberculosis is ignorance. Education is the only answer. The organized health departments, with their great army of workers, having daily contact with tuberculosis patients, their families, friends, and neighbors, are not only searching for new cases but are also educating lay groups where information about the disease in so necessary. R. D. Thompson, M.D., Nat. Tuberc. A. Bull., October, 1949.



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*of* **DYSMENORRHEA**

'Edrisal' does more than relieve the pain and lift the mood of your dysmenorrhea patient. Because it contains 'Benzedrine' Sulfate, 'Edrisal' also works to relieve the cramps so often associated with this painful period. Janney has observed: "The most satisfactory antispasmodic drug for use in spastic dysmenorrhea is, in my experience, Benzedrine Sulfate . . ."*

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Phenacetin . . . 2.5 gr.

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*Janney, J.C.: Dysmenorrhea, Medical Gynecology, Philadelphia, W.B. Saunders, 1945.

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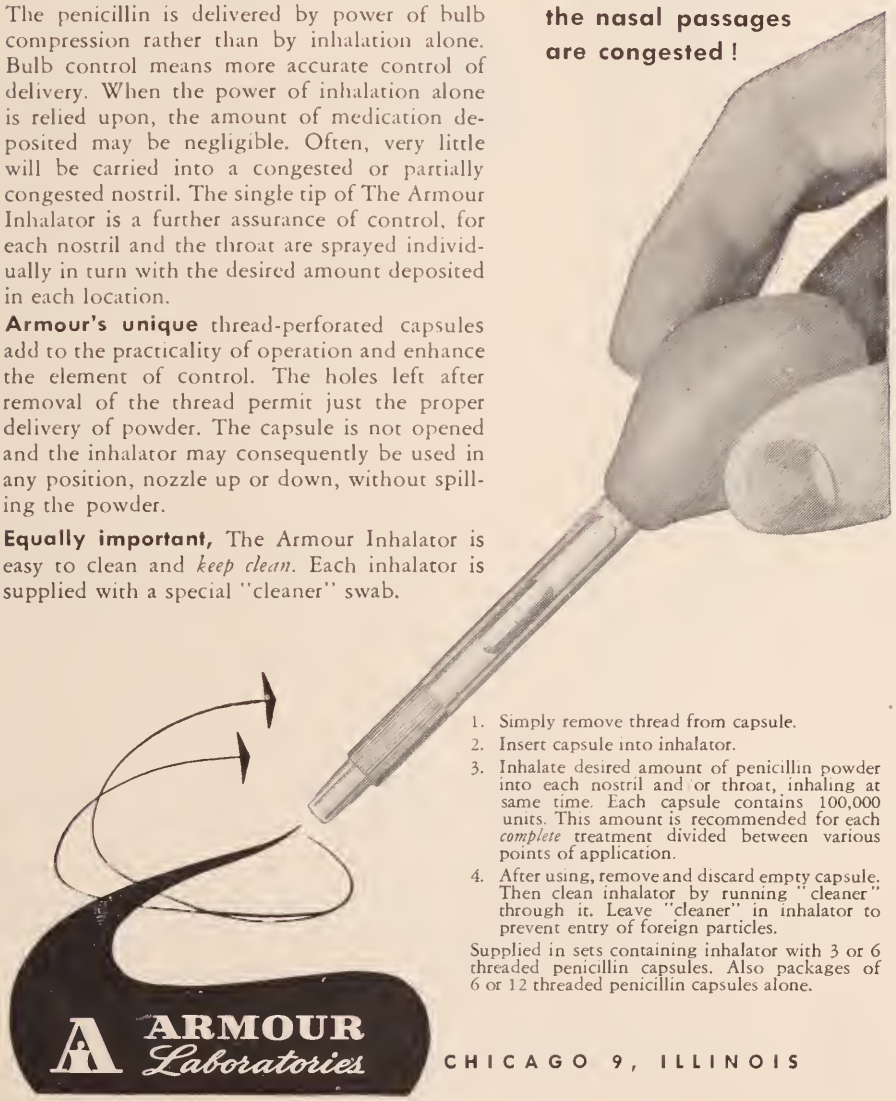
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4. After using, remove and discard empty capsule. Then clean inhalator by running "cleaner" through it. Leave "cleaner" in inhalator to prevent entry of foreign particles.

Supplied in sets containing inhalator with 3 or 6 threaded penicillin capsules. Also packages of 6 or 12 threaded penicillin capsules alone.

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# PHYSICAL MEDICINE ABSTRACTS



## THE GENERAL PRACTITIONER LOOKS AT THE FEET

Edwin Matlin. M.D., Mt. Holly Springs, Penna. AMERICAN PRACTITIONER, 1:2:172, February 1950.

One of the most common complaints to be found in all walks of life, one which is seen least frequently by a physician, one which is of least interest to a physician, and one which properly belongs in the realm of the physician, is that of painful feet.

It has been estimated that 80 per cent of the population has at one time or another been bothered with "foot trouble," and yet only a handful are treated in a general practitioner's office. The explanation is, of course, that they are referred by the family physician, or by a friend, to podiatrists, chiropodists, and sometimes to unscrupulous persons.

It is a fact that when interest is lost in any part of the practice of medicine there arises a group of people, who may be legitimate, or cultists, or unscrupulous persons, who are only too happy to take over a lucrative field. When the physician generally evinces an interest in heretofore largely ignored phases of medicine, then these offshoots disappear, as the midwife disappeared when the physician took over the practice of obstetrics.

The practitioner's lack of interest in foot care springs directly from his lack of knowledge. In medical school, little or no attention is given to the treatment or diagnosis of foot ailments, and it has always been much easier to refer a patient to a minor "specialist" than to play around with "someone's dirty smelly feet."

In this paper a few of the more common disorders and their treatment will be pointed out.

Rest and short wave diathermy treatment may be combined, the first to avoid unnecessary trauma, and the second to increase circulation to carry off the toxins produced by destruction of tissues following trauma. They are indicated in acute conditions, after the first 24 to 36 hours. In acute conditions, I feel that strappings or the application of heat and cold are contraindicated. The trauma causes edema due to the rupture of small blood vessels. Strapping at this time may interfere with the circulation as the swelling progresses, and the application of either heat or cold by increasing the circulation and causing a vasodilatation will increase the swelling and bleeding also.

The general practitioner has failed to render the service a patient justly deserves and expects to receive, when he overlooks or is disinterested in the patient's feet. A few of the more common difficulties are described, and methods of treatment are outlined. An awakening of interest on

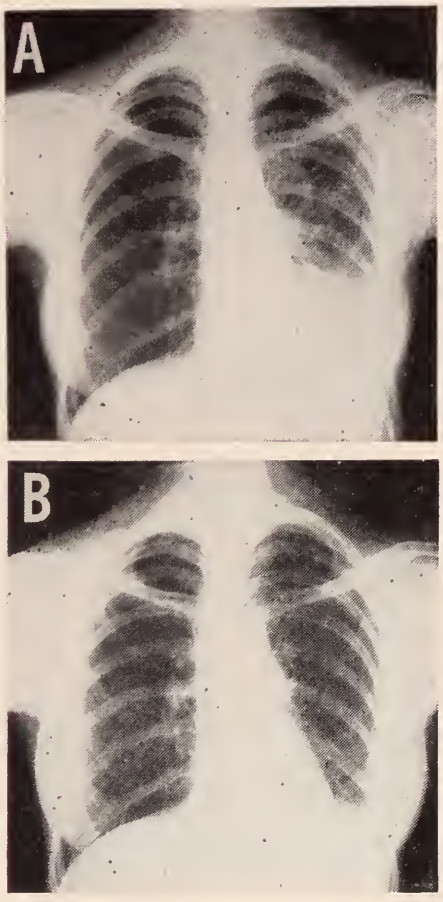
(*Continued on page* 44)

# Effective Chemotherapy in TUBERCULOSIS

DIHYDROSTREPTOMYCIN or Streptomycin, used alone or in combination with para-aminosalicylic acid, is recognized as a valuable and, in some instances, an essential adjuvant in the treatment of selected types and stages of tuberculosis.

Para-aminosalicylic acid is capable of inhibiting or significantly delaying the emergence of bacterial resistance to dihydrostreptomycin or streptomycin.

These drugs are not to be regarded as substitutes for traditional therapeutic methods. Rather, they serve best when properly integrated with bed rest and, where necessary, collapse measures or other forms of surgery.




**A. Before Treatment**
*(9 days prior to Dihydrostreptomycin therapy) Diffuse lobular tuberculous pneumonia, lower half of left lung; thin-walled cavity above hilus (3 x 3.5 cm.).*

**B. After 3 Months' Treatment**
*(2 days after discontinuance of Dihydrostreptomycin) Considerable clearing of acute exudative process in the diseased lung; cavity smaller and wall thinner.*

Detailed literature on the subject of chemotherapy in tuberculosis will be supplied upon request.

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the part of the general practitioner will result in a more adequately cared-for patient.

## CONGENITAL DISLOCATION OF THE HIP

Edward L. Compere, M.D., and William J. Schnute, M.D., Chicago, Ill. In QUARTERLY BULLETIN OF NORTHWESTERN UNIVERSITY MEDICAL SCHOOL, 24:1:34, Spring 1950.

The congenital dislocation or subluxation of the hip which is unrecognized until the child is 4 or 5 years of age will never become a normal functioning articulation. Many cases of coxa plana, coxa magnum, degenerative arthritis in the young-adult, and malum coxae senilis in the older patient are caused by subluxation of the hip which was not recognized and not treated adequately during infancy.

The unreduced congenitally dislocated hip results in shortening, marked limp, and sooner or later pain upon walking.

The plan of care for congenital dislocation of the hip which we have found very satisfactory is outlined as follows:

(1) Early and atraumatic reduction.

(2) The so-called "frog leg" cast with 90 degrees abuction and external rotation for three months.

(3) A spica cast, with the leg on the side of the dislocation abducted and internally rotated, for a period of two months.

(4) A position of wide abduction maintained by bilateral long leg casts, held spread apart by a plaster strut for a period of two months. The child is permitted to sit up and move about as freely as the spreader cast will permit.

(5) A modified Denis Browne splint with a wide bar which holds the legs in as much abduction as can be comfortably maintained. During the first few weeks after application of this splint it is removed for an hour or two each day during and following the bath. If the hip is found to be stable during these periods without the splint, it is gradually left off until after two months it is no longer worn at all during the day. It should be worn as a night splint for 12 out of each 24 hours until roentgenograms show normal depth of the acetabulum and a well formed and well rounded head of the femur. During this period of night splinting, which may be continued for one to five years, the shoe position on the splint is gradually changed from one of internal rotation to that of slight external rotation. As a result of this positioning of the shoe and hence control of rotation of the legs, the anteversion of the femeral neck has been observed to diminish as further growth occurred.

## EFFECT OF HOT PACKS ON PERIPHERAL CIRCULATION

Edward M. Krusen, Jr., M.D., Kahlil Wakim, M.D., Ursula M. Leden, M.D., Gordon M. Martin, M.D., and Earl C. Elkins, M.D., Rochester, Minn. In ARCHIVES OF PHYSICAL MEDICINE, 31:3:145, March 1950.

The purpose of this study was twofold: (1) to study the effect of hot packs on the peripheral circulation of man and (2) to compare the effectiveness of different methods of packing.

This study shows that hot moist packs do produce rises in the temperature of the skin and increases in blood flow. The rises in the cutaneous temperatures are maintained above those of the control for at least one and a half hours, but in approximately one hour after application of packs the temperatures level off. However, it is obvious that the increases in blood flow are not so well maintained. Sometimes between forty-five and ninety minutes after application packs become relatively ineffective so far as effects on circulation are concerned. These data indicate that one set of packs should not be applied for longer than forty-five minutes.

In general, the repeated applications of packs every fifteen minutes did raise cutaneous temperatures and the blood flow to higher levels than did single applications for thirty and forty-five minutes, but the absence of a statistically significant difference in blood flow suggests that frequent changing of packs (every fifteen minutes) may be of no great value, as well as adding to the problem of nursing care. Repeated applications of packs at longer intervals, however, were not included in this study.

Technically, it was found that packs produce their greatest effect if placed on the subject when they are hot as can be tolerated (about 104 F. five minutes after application) and are fairly moist. Difficulty was encountered in getting satisfactory rises in temperatures of the skin or increases in blood flow if these conditions were not satisfied. Proper care should be exercised

(*Continued on page* 46)



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## Physical Medicine (Continued)

in applying fairly moist packs to prevent burning.

Whether the changes of circulation produced by packs are as great as those produced by other methods of heating is questionable. Wakim, Krusen and Elkins found an average increase in the blood flow of the arms of 6.5 cc. per hundred cubic centimeters of tissue ten minutes after the patient's oral temperature had been raised to 101 F. by hot baths. This was a greater increase than that obtained by any method of packing in our study, in which the largest increase was 5.0 cc. per hundred cubic centimeters of tissue. The highest oral temperature attained with packing was only 100.3 F. Hipps and Crook and Gurewitsch and O'Neill have suggested the use of hot baths in the treatment of poliomyelitis. Of course, in certain circumstances, for example when the patient is in isolation, baths are not practical and packs may be the most satisfactory form of heating.

Fifty sets of determinations were made on the effects of hot packs on the temperature of the skin and on blood flow in the extremities. The following observations were made:

(1) The temperature of the skin definitely was raised by packing. The temperatures of the packed portions fell gradually, leveled off about an hour after application of packs and were maintained above control values for at least ninety minutes.

(2) Packing for fifteen, thirty and forty-five minutes produced significant increases of blood flow. This does not indicate, however, that such applications employed once daily would produce satisfactory therapeutic results.

(3) After the application of a single set of packs to the extremities for ninety minutes there were no significant increases of blood flow in the arms and legs.

(4) After the application of a single set of packs to the extremities, back and neck for ninety minutes there were significant increases of blood flow in the arms, but not in the legs.

(5) When packs were applied to the extremities unilaterally, insignificant increases of blood flow were produced in the contralateral extremities.

(6) Greater increases of blood flow in the legs

(*Continued on page* 48)

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Merrell
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[1]Hansel, F. K.: Ann. Allergy, 1:199-207, 1943

may be produced by packs left on for longer periods.

(7) The addition of back packs and repetition of packing every fifteen minutes produced insignificant differences in the increase of blood flow.

### POLIOMYELITIS: INFECTIOUS OR METABOLIC?

W. J. McCormick, M.D., Toronto, Canada. In ARCHIVES OF PEDIATRICS, 67:2:56, February 1950.

The marked resemblance in the epidemiology, symptomatology and pathology of poliomyelitis and beriberi is presented in support of the author's hypothesis of vitamin $B_1$ deficiency as the basic etiological factor in poliomyelitis. As additional evidence a close parallel is drawn between the recent poliomyelitis outbreak in the Canadian Arctic and that of the island of Nauru (1910) from the nutritional angle.

The modern concept of the virus as a chemical substance, a protein molecule of definite dimension, rather than an ultramicroscopic organism, as previously thought to be, calls for a revision of the interpretation of the Flexner experiments as to specificity and transmissibility of the disease, with consideration of the possibility of the endogenous or metabolic origin of the virus.

It is suggested that the paralytic phenomena in poliomyelitis may be indirectly referable to acute $B_1$ avitaminosis precipitated by converging factors which increase the metabolic rate and accordingly the bodily requirement for this vitamin, such as febrile conditions, age, sex, climatic conditions, physical overexertion in work or play, and pregnancy; and that the paralysis may be a secondary metabolic manifestation rather than a primary infectious disease.

The associated virus is regarded as a biochemical substance produced by the disease, which, although capable of producing paralysis in experimental animals by catalytic chemical action in the nervous system, is not necessarily a means of spread of the disease under ordinary conditions. It is suggested that a virus-like substance may be obtainable from the nerve tissues of beriberi victims — an experiment which apparently has not yet been attempted.

(*Continued on page* 50)


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No interference with normal bowel function[1]
No alteration of acid-base balance of body fluids[2]
No toxicity even with massive dosages[3]

[1]Kraemer, M.: Postgrad. Med. 2:431 (Dec.) 1947.
[2]Kraemer, M., and Siegel, L. H.: Arch. Surg. 56:318 (Mar.) 1948.
[3]Martin, G. J., and Wilkinson, J.: Gastroenterology 6:315 (Apr.) 1946.

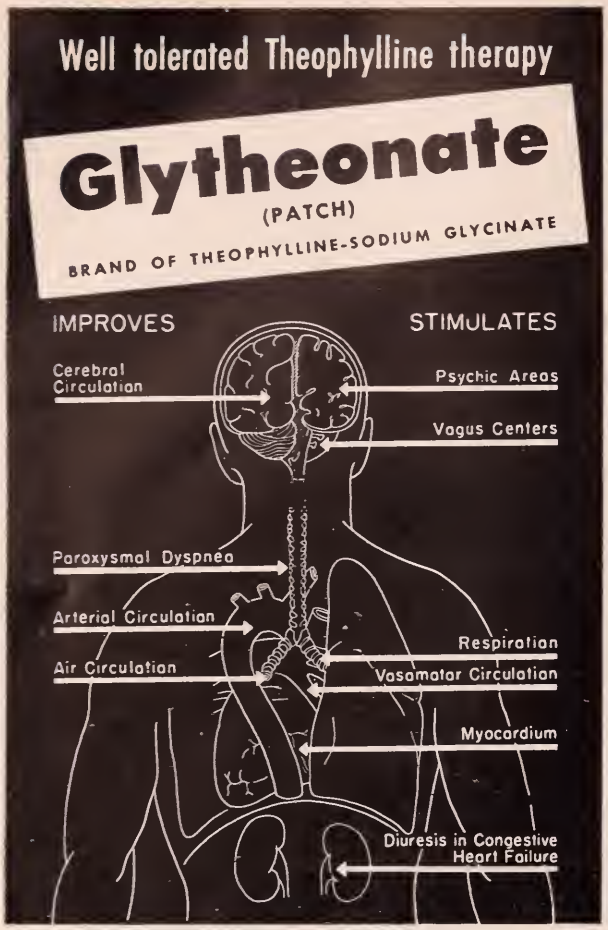
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**SUPPOSITORIES** (Rectal)—containing theophylline-sodium glycinate 0.78 Gm. (12 grs.), representing theophylline U.S.P., 0.39 Gm. (6 grs.). Boxes of 12 suppositories.

Also tablets with Phenobarbital, tablets with Phenobarbital and Racephedrine and tablets with Phenobarbital and Rutin.

1. Paul, W. D., and Montgomery, A. E.: J. Iowa State M. Soc. *38*:237 (June) 1948.
2. Bubert, H. M. and Cook, S.: S. Med. Journ. *41*:146 (Feb.) 1948.

THE E. L. PATCH COMPANY, Stoneham, Mass.


## Physical Medicine (Continued)

### THE PHYSICAL THERAPY DEPARTMENT

Leigh T. Wedlick, M.R.C.P. (Lond.), Honorary Physical Therapist, Royal Melbourne Hospital, Melbourne, Australia. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 13:3:57, March 1950

The physical therapy department should not be an isolated department; it is a vital link in the chain of hospital treatment, and it impinges not only on general medicine and surgery, but on all the specialties.

In the establishment of a physical therapy department I consider that the first essential is the appointment of a medical director.

The technicians who administer the actual treatments should be fully trained physical therapists, working under the direction and close supervision of the medical director. The use of semi-trained technicians, or of nurses who are not fully acquainted with the technical side of the work, can only lead to bad results.

---

### PHYSICAL MEDICINE IN GENERAL PRACTICE

Sedgwick Mead, M.D., St. Louis, Mo. In POST-GRADUATE MEDICINE, 7:1:54, January 1950.

A few conditions are illustrated which are among the commonest encountered in a physical medicine practice and which give the most gratifying results to treatment. Equipment is simple.

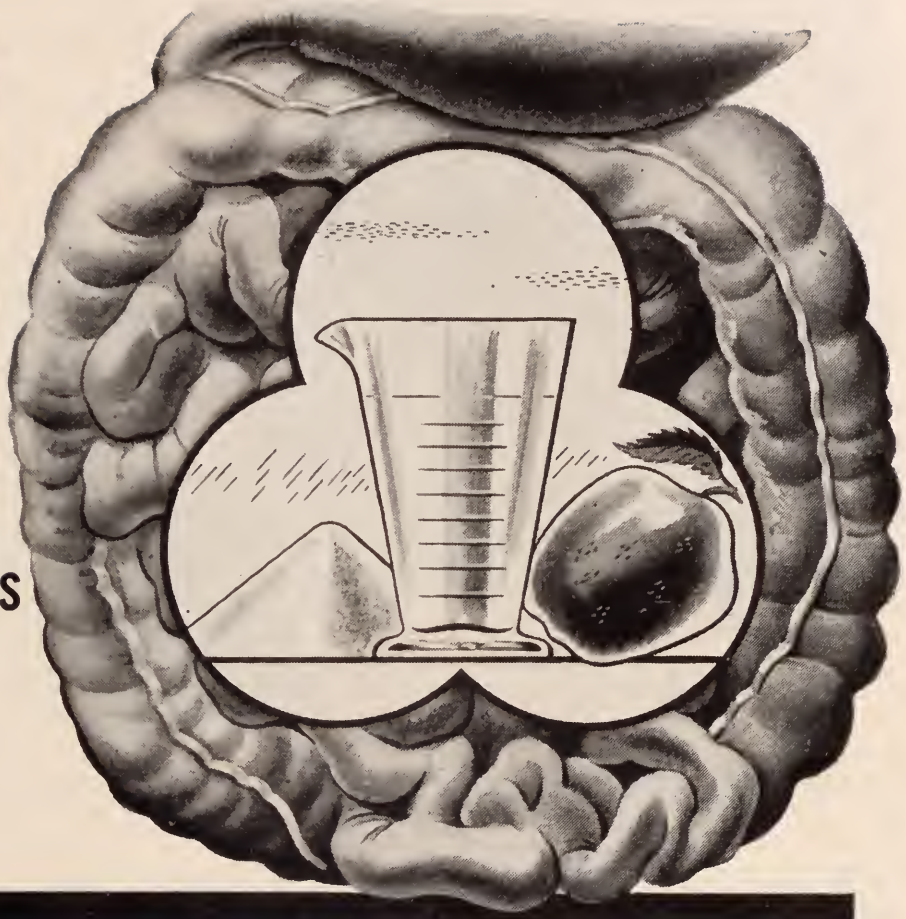
Even more important than the equipment are the services of a skilled assistant. Beware the pitfalls of employing receptionists and other persons to administer treatments about which they know nothing.

An ideal arrangement for a group medical practice would be to pool resources for equipment and hire a physical therapist. Be sure she is registered by the American Registry of Physical Therapy Technicians. This will insure that she trained at a school meeting the minimum requirements of the Council on Hospitals and Medical Education of the American Medical Association. It will also insure that she is an ethical medical aide who does not illegally practice medicine on her own.

Write detailed and intelligent prescriptions. Do not expect the physical therapist to make diagnoses or assure too much responsibility for the objectives of treatment. She is there to carry out the details accurately and safely.

(*Continued on page* 54)

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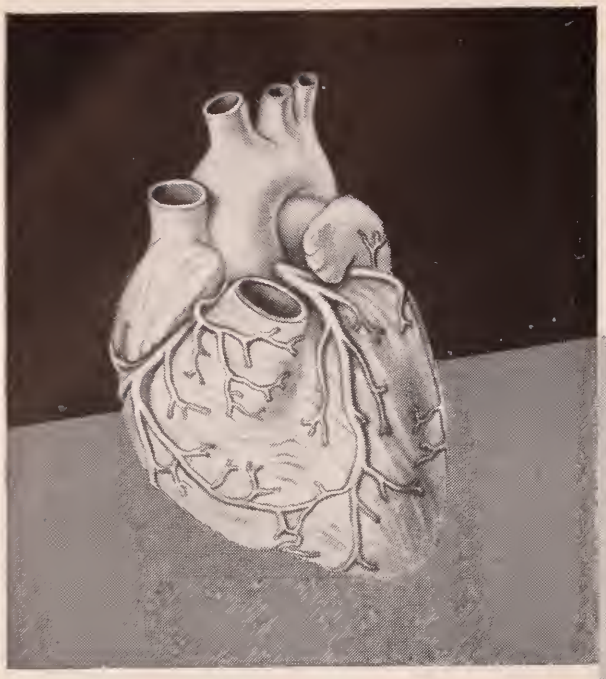
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to be at least *5 times the coronary dilating activity of aminophyllin.*)[1]
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1. Killam, K.R., and Fellows, E.J.: Federation Proc. 9:291 (March) 1950.
2. Rosenman, R.H., et al.: J.A.M.A. 143:160 (May 13) 1950.
3. Osher, H.L., and Katz, K.H.: Boston M. Quart. 1:11 (March) 1950.
4. Kenawy, M.R., et al.: Eye, Ear, Nose & Throat Monthly 29:79 (Feb.) 1950.


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## Physical Medicine (Continued)

### STROKES — THEIR EVALUATION AND TREATMENT

Abe B. Baker, M.D., Minneapolis, Minn. In JOURNAL OF IOWA STATE MEDICAL SOCIETY, 40:3:107, March 1950.

The term *stroke* has, over a period of time, become associated with two concepts, one, clinical and one, pathologic. Clinically, it has become restricted to the acute onset of motor manifestations such as weakness or paralysis; pathologically, it has been limited to lesions resulting almost exclusively from a cerebrovascular accident. Actually both of these inferences are for the most part incorrect. It might be best to first consider the clinical implications of a so-called stroke:

The term *stroke* as it is used today indicates some focal symptom of brain dysfunction. If such an assumption is correct, then the manifestations of the stroke will be as varied as the accepted function of the brain itself. The physician generally is not concerned with the more finite disturbances of brain function and may well avoid such disturbances in a routine diagnosis.

The immediate care of the stroke patient consists of general medical treatment and good nursing care. Medical procedures and therapy for the underlying disease is begun immediately upon arrival at the hospital. Nursing care of these patients is of the utmost importance in order to (1) prevent contractures (by passive movements of the extremities through a full range of movement), (2) avoid hypostatic pneumonia (by frequent change of patient's position, removal of nasal and oral secretions), (3) prevent decubital ulcers (by close attention to skin hygiene), (4) institute a schedule for eating, bowel habits, waking and sleeping as the patient begins to improve. The nurse because of early contact with the patient, encouraging him to help himself, is the first step in rehabilitation.

Most stroke patients, depending upon the severity and cause of the involvement, are kept in bed from three to six weeks. As soon as the acute symptoms have subsided and while the

(*Continued on page* 56)

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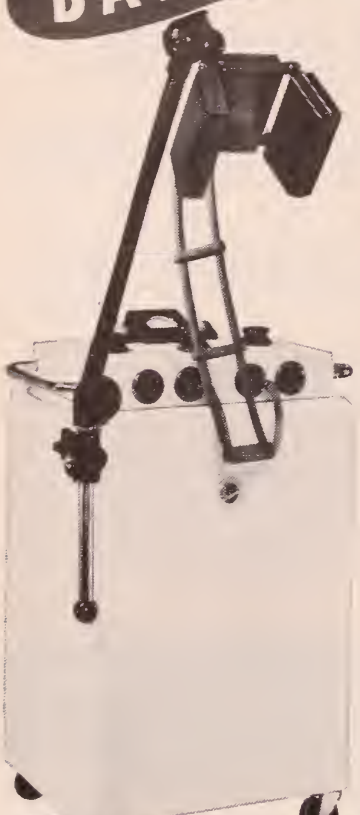
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patient is still bedridden, physical therapy should be instituted to prevent deformities by the use of passive movement. Between therapy periods, footboards, sandbags and splints may be used to maintain proper position of the limbs. As the patient improves, he is encouraged to use the affected extremity as much as possible and to care for his own bedside needs. Heat, massage and hydrotherapy may be used for painful joints and extremities.

Ambulation is started when the patient is strong enough to bear weight on the affected limb. He usually is started by balancing within parallel bars and progresses through the normal stages of ambulation, namely, crutch gaits, cane gaits and, when possible, walking without aids. Special attention should be given to stair climbing.

Speech therapy often is helpful in patients with speech disturbances and should be instituted early. Because of their disability, many of these patients may have to learn new vocations.

This process of rehabilitation of the stroke patient is an important part of the total treatment program and must be instituted in every case. It generally can be carried out, even in the home, provided that the physician understands his goal, is sympathetic toward it and is willing to spend a little time with the family and the patient in outlining and directing the course of therapy. Members of the family can be taught to carry out passive movement in appropriate cases. Self-care and ambulation activities, particularly in milder cases, may not need a trained therapist and can be carried on by the family under the supervision of the physician.

The outlook for functional recovery naturally is variable from patient to patient and can be determined only by careful neurologic evaluation from time to time. All patients with a hemiplegia, however, regardless of the degree of recovery, are capable of ambulation if given adequate rehabilitation therapy.

---

A mycotic infection should be suspected in every patient who has chronic draining sinuses even though the clinical appearance of the lesions may be identical with those produced by the tubercle bacillus and by certain anaerobic streptococci. David T. Smith, M.D., J.A.M.A., December 24, 1949.



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# BOOK REVIEWS



ELECTROCARDIOGRAPHY — Fundamentals and Clinical Application: By Louis Wolff, M.D. Visiting Physician, Consultant in Cardiology and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; Associate in Medicine, Harvard Medical School. 187 pages with 110 figures. Philadelphia & London: W. B. Saunders Company, 1950. Price $4.50.

The author has added to a long list of books, an additional text on the subject of electrocardiography. He states in the preface that many subjects are taught empirically with the student only having to memorize a few patterns and values. Thus, little knowledge is retained. He has approached his subject from the understanding of the basic principles of electrocardiography without reference to a pattern.

The book is divided into two parts: the basic principles of electrocardiography, and clinical electrocardiography. In the first part the how and why of electrocardiography is developed step by step according to physiologic principles. The author explains what is meant by depolorization, repolorization, exploring electrode, indifferent electrode, and unipolar leads. Instead of making his subject mechanical he has made it physiological.

The second part of the book develops from the principles of the first part. The usual cardiac conditions applicable to electrocardiography are discussed. Although brief, the author has accomplished a worthwhile end by producing a practical text on a technical subject by presenting an understanding instead of a collection of patterns.

J.W.F.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

A HISTOLOGY OF THE BODY TISSUES — With a Consideration of Their Functions. By Margaret Gillison, Diploma of Bedford Physical Training College, Diploma in Physical Education of the University of London, Member of the Chartered Society of Physiotherapy, Lecturer in Physiology at the I. M. Marsh College of Physical Education, Liverpool. Foreword by R. C. Garry, D.Sc., M.B., Ch.B., F.R.S.E., Regius Professor of Physiology, University of Glasgow. The Williams and Wilkins Company, Baltimore, 1950. 220 pages. $3.50.

RECENT ADVANCES IN CHEMOTHERAPY — Third Edition — Volume 1. By G. M. Findlay, C.B.E., Sc.D., M.D., F.R.C.P., Editor, Abstracts of World Medicine and Abstracts of World Surgery, Gynaecology and Obstetrics, British Medical Association, London. The Blakiston Company, Philadelphia, Pa., Toronto, Canada. 625 pages. $7.50.

COMMUNICABLE DISEASES. Edited by Roscoe L. Pullen, A.B., M.D., F.A.C.P., Professor of Graduate Medicine, Director of the Division of Graduate Medicine, and Vice-Dean, School of Medicine, Tulane University of Louisiana; Senior Visiting Physician, Charity Hospital of Louisiana, New Orleans. 53 Contributors. 253 figures, 35 illustrations on 20 color plates. Lea & Febiger, Philadelphia, 1950. 1035 pages. $20.00.

Essentials Of Ophthalmology. By Roland I. Pritikin, M.D., F.A.C.S.F.I.C.S., Eye Surgeon, Rockford Memorial, Winnebago County and Swedish-American Hospitals, Consulting Ophthalmologist, St. Anthony Hospital, Rockford, Illinois. J. B. Lippincott Company, Philadelphia, London, Montreal. 561 pages, 215 illustrations, including 18 subjects in colors. $7.50.

Clinical Electrocardiography. By Francis F. Rosenbaum, M.D., Assistant Clinical Professor of Medicine, Marquette University School of Medicine, Staff, Milwaukee County Hospital, Associate Staff, Columbia Hospital. Adjunct Staff, Milwaukee Children's Hospital; Cardiac Consultant and Attendant, Cardiac Clinic, Milwaukee Children's Hospital. Milwaukee, Wisconsin. Edited by Henry A. Christian, A.M., M.D., LL.D., Sc.D. (Hon.), M.A.C.P., Hon. F.R.C.P. (Can.), D.S.M. (A.M.A.) Oxford University Press, 1950. $4.50.

The Mask Of Sanity — An Attempt to Clarify Some Issues About the So-Called Psychopathic Personality. By Hervey Cleckley, M.D., Professor of Psychiatry and Neurology, University of Georgia School of Medicine, Augusta, Georgia. Second Edition. The C. V. Mosby Company, St. Louis, 1950. 569 pages. $6.50.

World Surgery, 1950. By Stephen A. Zieman, M.A., M.D., F.A.C.S., F.I.C.S., Abstract and News Editor, Journal of the International College of Surgeons, Abstractor for International Abstracts of Surgery and Surgery, Synecology and Obstetrics. Formerly Assistant Chief, Bureau of Publications, U. S. Navy Medical Department, and Assistant Editor, U. S. Navy Medical Bulletin. 177 pages. J. B. Lippincott Company, Philadelphia, London, Montreal. 53 illustrations.

Management Of Peripheral Arterial Diseases. By Saul S. Samuels, A.M., M.D., Chief of the Department of Arterial Diseases, Stuyvesant Polyclinic Hospital, New York. Consulting Vascular Surgeon, Long Beach Hospital, Long Beach, New York; Director and Attending Angiologist, Brooklyn Hebrew Home and Hospital for Aged, Brooklyn, New York; Fellow in Surgery, New York Academy of Medicine; Member of Committee on Surgery, New York Diabetes Association; Editor-in-Chief, "Angiology"; President, Angiology Research Foundation. Oxford University Press, New York, 1950. 345 pages. $7.50.

Essay On The Cerebral Cortex. By Gerhardt von Bonin, M.D., Professor of Anatomy, College of Medicine, University of Illinois, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. 150 pages. $3.75.

Peptic Ulcer. By A. C. Ivy, Ph.D., M.D., D.Sc., LL.D., Vice President of the University of Illinois in Charge of Chicago Prefessional Colleges; M. I. Grossman, Ph.D., M.D., Associate Professor of Physiology, University of Illinois, College of Medicine; and William H. Bachrach, Ph.D., M.D., Research Associate in Physiology, University of Southern California, School of Medicine. 137 illustrations,


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## BOOKS RECEIVED (Continued)

210 tables. 1144 pages. The Blakiston Company, Philadelphia, Pa., Toronto, Canada, 1950. $14.00.

REGIONAL DERMATOLOGIC DIAGNOSIS — A Practical System of Dermatology for the Nonspecialist. By Ervin Epstein, M.D., Consultant in Dermatology and Syphilology to the Oakland Area Veteran's Hospital and Mt. Zion Hospital; Consultant to the Tumor Board at the Highland-Alameda County Hospital; Co-Editor of "Dermatologica" (International Journal of Dermatology); Abstract Staff of "Excerpta Medica"; Diplomate of the American Board of Dermatology and Syphilology; Member of American Academy of Dermatology and Syphilology and of the Society for Investigative Dermatology; Former president of the San Francisco Dermatological Society; Secretary-treasurer of the Pacific Dermatologic Association; Secretary of the Section on Dermatology and Syphilology of the California Medical Association. Lea & Febiger, Philadelphia, 1950. 328 pages. 148 illustrations. $6.00.

GENEALOGY OF GYNAECOLOGY (Second Edition) By James V. Ricci, M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Attending Gynaecologist, City Hospital, New York; Consultant in Gynaecology and Obstetrics, Beekman-Downtown Hospital; Director of Gynaecology and Obstetrics, Columbus Hospital; Fellow of the New York Academy of Medicine. The Blakiston Company, Philadelphia, Pa. and Toronto, Canada. 494 pages. $8.50.

PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS. By Paul Haun, M.D., Med. Sc. D., Assistant Professor of Psychiatry, Georgetown University Medical School. Architectural Record, 119 West 40th Street, New York 18, N. Y., 1950. 80 pages. $4.00.

HUMAN STERILIZATION — Techniques of Permanent Conception Control. By Robert Latou Dickinson M.D., and Clarence James Gamble, M.D. Waverly Press, Inc. 40 pages.

PARKINSON'S DISEASE — Advice and Aid for Sufferers of Parkinson's Disease and Other Physical Disabilities. By Walter Buchler, 101, Leeside Crescent, London, N. W. 11 England. 79 pages. $1.00.

TRANSACTIONS OF THE AMERICAN GOITER ASSOCIATION: 1949 Annual Session, May 26, 27, 28, Hotel Loraine, Madison, Wisconsin. Springfield, Illinois, Charles C. Thomas. 1950. 460 pages. Price $10.50.

MULTIPLE SCLEROSIS AND THE DEMYELINATING DISEASES: Proceedings of the Association, December 10 and 11, 1948, New York. 675 pages, with 153 illustrations and 124 tables. Baltimore, Williams & Wilkins Company, 1950. Price $12.00.

HARVEY CUSHING: Surgeon, Author, Artist. By Elizabeth Thompson. Foreward by John J. Fulton. Illustrated. New York, Henry Schuman, Inc., 1950. Price $4.00.

THE LAW OF MEDICINE: By Parnell Callahan, A. B., LL. B., and Justin Callahan, A. B., M.D., New York, Oceana Publications. 80 pages. Price: $1.00 paper-bound, $2.00, cloth-bound.

## RECENT ADVANCES IN THE TREATMENT OF NEUROSYPHILIS

Experience with 446 cases of neurosyphilis, of whom 377 were under follow-up, treated over a period of five years supports the general conclusion that: (1) Intramuscularly administered penicillin for a fifteen-day course, repeated when necessary, is the most effective single form of therapy; (2) fever therapy combined with penicillin in general paresis and primary optic atrophy frequently brings a better clinical response than penicillin alone in the first year or two after treatment, although they may be about the same after that; (3) prognosis improves with early treatment before irreparable damage occurs; (4) newer treatments have apparently reduced the number of cases admitted to psychiatric institutions.

Psychotherapy, especially electroshock, should be used in combination with antisyphilitic treatment when indicated. However, in regard to the problem of syphilis as a whole, the nature of the disease requires additional time before treatment results can definitely be evaluated. Consequently, an attitude of caution and preparedness should be preserved.—*Augustus S. Rose, M.D., North Carolina Medical Journal, September, 1949.*

## THE IMPERFORATE HYMEN

Imperforate hymen is clinically important though not common. It is produced by the failure of the centrally located epithelial cells of the posterior wall of the hymen to degenerate. This naturally prevents the mucus and blood from flowing out of the vagina and they begin to dam back producing in order hematocolpos, hematotrachelos, hematometrius and hematosalpinx. If the hymen is not taken care of one of two things may happen—it may rupture or an infection may occur. This condition must be considered in differential diagnosis whenever amenorrhea is associated with difficulty in urination and pain in the lower abdomen.

The treatment consists of making cruciate incisions to allow the dammed up fluid to run out slowly, then excising the central area and suturing the cut edges. Postoperatively, Fowler's position is desirable. *Excerpt: Imperforate Hymen with Hematocolpos, Case Report, Walter W. Daniel, M.D., F.I.C.S., Atlanta, The Southern Surgeon, May, 1950.*

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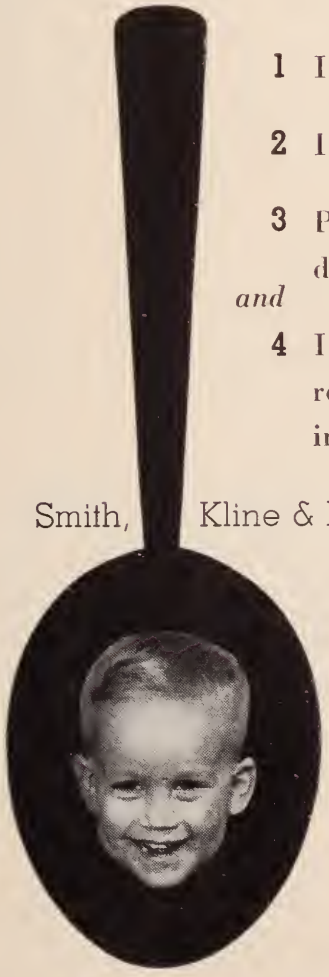
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## NUTRITION OF CHILDREN OFTEN IS UNSATISFACTORY

Application of nutrition to children has not kept pace with present-day knowledge, according to a report to the Council on Foods and Nutrition of the American Medical Association.

"In a general way we have done reasonably well nutritionally for our babies, but not so well for children past infancy," points out Dr. Philip C. Jeans of Iowa City in the March 18th Journal of the A.M.A.

Nutrients most commonly found deficient in diets of children are vitamin D; calcium; riboflavin and thiamine (factors of the vitamin B complex); protein, and vitamin C, Dr. Jeans says.

"Vitamin D commonly is deficient in the diet of the child," Dr. Jeans emphasizes. "Many children receive an inadequate amount of sunshine in the summer and few receive a sufficient amount in winter. Giving vitamin D preparations has become routine in infancy, but relatively few mothers realize that vitamin D is important throughout the growth period."

Milk is the only constant good food source of calcium, Dr. Jeans says. Calcium deficiency, at least in moderate degree, is believed to be widely prevalent in childhood. A quart of milk daily contributes an abundance of calcium and supplies most of the protein need of the young child and half the protein need at the beginning of adolescence.

Use of whole grain cereals and enriched or fortified cereal foods contributes importantly to the satisfaction of needs of children for the vitamin B complex factors, according to the report. Eggs also contribute importantly to the supply of B vitamins and should be included in the diet frequently, preferably daily.

Data indicate that the great majority of children studied have a protein intake below that needed for best nutrition. The weight of such children usually is within what is considered the normal range. Vitamin C can be supplied by eating citrus fruit or tomatoes daily.

Lack of appetite in children brought to pediatricians usually is dependent on training in feeding habits and usually originates in infancy, the report says.

"The interrelationships which are set up between mother and child during the early days and weeks after birth set a pattern which is important in determining the response the child will have toward eating."

An infant fed by an impatient or exasperated mother is not likely to eat well or digest his food satisfactorily. Changes in the type of food or manner in which it is given may be upsetting to a baby and are best made when the infant is in a mood to accept them.

"Feeding by both parents is helpful in fostering emotional development," the report says. "The infant's manual preparedness in feeding develops

*(Continued on page 64)*

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**NUTRITION (Continued)**

after six or seven months and should be encouraged so far as is feasible. Acceptance of new foods is affected greatly by the attitude of the mother toward these foods. If a mother has a revulsion toward a food, communication to the baby of her emotional state is common, with the result that the baby refuses the food.

"The so-called self-demand schedule has become fairly common. Much is to be said in favor of having the baby's feeding time when he is most frequently hungry. Usually such a schedule is regulated by the mother. Thus the schedule is easily subject to abuse and the baby may be fed every time he cries, a procedure that leads to faulty feeding habits."

## GROWTH OF HEALTH COUNCILS SHOWS NATIONWIDE PROGRESS IN RURAL HEALTH

One of the brightest indications of progress in securing more doctors and better health facilities for rural areas is the announcement by the American Medical Association that community health councils in the nation have increased from 82 to nearly 300 in the last two years.

These figures are based on a recent survey of the association's Council on Medical Service in which county medical societies were queried, Thomas A. Hendricks of Chicago, secretary of the council, said.

Local achievements of the community health councils in the last five years include construction of hospitals with the aid of the Hospital Survey and Construction Act (Hill-Burton Act); increasing available hospital beds; developing clinics; securing more doctors, dentists, nurses and other needed personnel; development of full-time local public health services; health examination of children of school and pre-school age and correction of their remediable health defects; promotion of voluntary prepayment medical care and hospitalization; provision of medical care for the aged and chronically ill, and meeting costs of medical service to families unable to pay for hospitalzation and doctors' bills, according to Mr. Hendricks.

Some community councils have been extremely helpful in cooperating with the national mental health program. Councils have matched government funds to pay mental health clinic personnel and conducted educational campaigns to acquaint communities with the value and manner of operation of the clinics.

Although health councils have been organized in urban as well as in rural areas, they have been especially important in bringing better medical care to the people of rural communities.

The A.M.A.'s efforts to promote organization of community health councils to improve medical care




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for rural communities date back to the organization of the association's Committee on Rural Health five years ago. Since that time it has been actively engaged in coordinating the efforts of farm groups and state and local medical societies in rural health.

The committee is set up so that its representatives can be reached locally in any area. Doctors selected by state medical societies serve as directors in nine regions and as state rural health chairmen in 45 states. Any organization wanting information on setting up a local health council or solving rural health problems may contact one of these representatives or write directly to the A.M.A. Rural Health Committee in Chicago.

Dr. F. S. Crockett of Lafayette, Ind., is chairman of the Rural Health Committee, and a subcommittee of four doctors forms the executive body. Representatives of the American Farm Bureau Federation, the Grange, the Farm Foundation and other farm organizations make up an advisory committee.

Suppose members of the Farm Bureau in Ohio write the A.M.A. that a community needs a doctor and does not have the facilities to attract him. The community wants to build and staff a health clinic with aid from the Hospital Survey and Construction Act. What happens?

The explanation comes from Dr. Crockett. The information is referred to the regional director who takes the matter up with the state rural health chairman and the state medical society. The state chairman and the medical society contact the Farm Bureau, a meeting is called, and the state chairman and representatives of the state and local medical societies, farm organizations and civic groups get together at the community level to work out the problem.

That the rural health problem is steadily being solved through cooperative community efforts was generally agreed at the recent (Feb. 3-4) fifth annual Conferencee on Rural Health in Kansas City, Mo. The conference, sponsored by the Committee on Rural Health in cooperation with farm organizations, brought together more than 500 medical and lay leaders concernd with providing medical care to small communities.

---

One important epidemiologic principle in tuberculosis is that the disease, if diagnosed during its early stages, can be handled effectively. Thus, it is necessary to develop better technics for early detection of tuberculosis. Perhaps it is more important still to develop a more effective social machinery, so that this diagnostic service can be made readily available to all susceptible persons, and particularly for those who are at greatest risk. W. G. Smillie, M.D., New England J. Med., January 12, 1950.

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In many cases it was obvious that the patient was in acute pain. All of the patients held their neck stiffly, often slightly flexed to the side opposite the pain. All exhibited limitation of motion of the cervical spine and all complained of localized tenderness. In almost every patient there was spasm of the paravertebral muscles, especially on the side of the lesion.

Conservative therapy is initially the treatment of choice and is often all that is necessary. . . During the acute attack we believe an attempt should be made to relieve the muscle spasm with bedrest, narcotics, heat or diathermy, and cervical traction. Recently, we have found Tolserol to be of considerable aid in relieving muscle spasm.

If in spite of conservative therapy there is persistent incapacitating neck and arm pain, we believe that surgery is the treatment of choice. It can be done with a minimum of risk. The postoperative results are usually gratifying. *Excerpt: Lateral Rupture of Cervical Intervertebral Discs, A Review of Fourteen Surgically Treated Cases, Hugo V. Rizzoli, M.D., clinical instructor in neurological surgery, George Washington University School of Medicine; Captain Gordon T. Wannamaker, M.C. U.S.A., neurosurgical section, Walter Reed General Hospital; Major George J. Hayes, M.C., U.S.A., neurosurgical section, Walter Reed General Hospital, Medical Annals of the District of Columbia, June, 1950.*


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## HAZARDS IN TREATING INTRACTABLE PAIN

. . . Of almost equal importance to the awareness of the physician as to the availability of pain-relieving neurosurgical procedures is his understanding of the hazards and possible complications of such procedures. The relatives of the patient must be thoroughly schooled in all features of the case at hand. In particular, it must always be stressed that the operation is intended solely as a pain-relieving measure, is not an attack on the neoplasm and will not prolong the patient's life. The hazards of operation, as regards mortality and such factors as temporary bladder paralysis, must always be well understood by everyone dealing with the patient in any case. In the presence of truly intolerable pain, such hazards are almost always gladly accepted.

The optimum time for undertaking the procedures for the relief of intractable pain is early in the course of such pain. As soon as the diagnosis of an inoperable neoplasm is made and the patient begins to have pain, he should have proper attention to such pain.

. . . As far as the operation itself is concerned, an attempt should always be made to render analgesic not only the region painful at the time of operation but also those areas into which there might well be spread of pain. This simply means that a high level of analgesia should always be sought in cordotomy, numerous roots must be sectioned in rhizotomy and cervical rhizotomy should usually be added to trigeminal and glossopharyngeal nerve section. *Excerpt: Neurosurgical Procedures for the Relief of Intractable Pain, Charles E. Troland, M. D., Richmond. The Southern Surgeon, May, 1950.*

---

Such a program will fail completely unless the medical profession is made to understand thoroughly the philosophy of the program, namely, that it does not take the place of the physician in making a diagnosis. In fact, no diagnosis will be made. Only suspected abnormalities will be screened out in this first procedure; the diagnosis will be made later in the physician's office and, it is hoped, at a stage when the physician may be more effective in administering treatment than would have been the case if the patient had waited until the development of full-fledged symptoms forced him to consult a physician. James E. Perkins, M.D., Bull. Nat. Tuberc. A., January, 1950.

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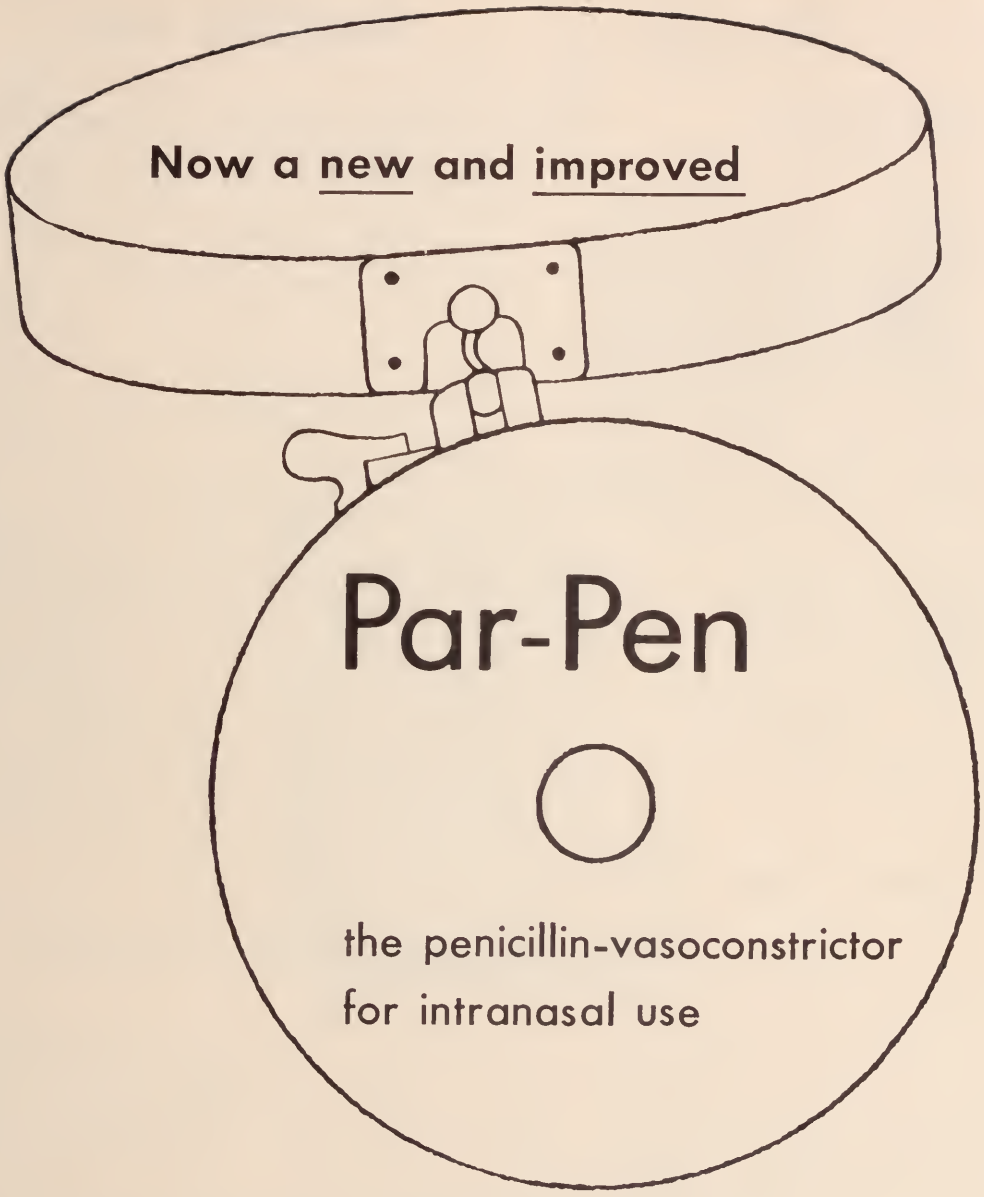
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# Medical Journal

VOL. 98 NO. 3

*September, 1950*

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## Penicillin in the Treatment of Congenital Syphilis

(See page 5 for Table of Contents)

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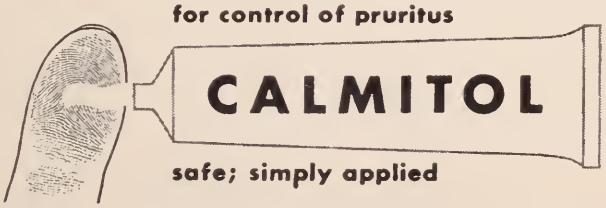
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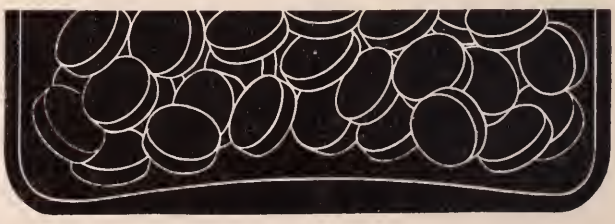
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"I have played on softball teams, was chosen as a member of the All-Star team, play tennis, and enter into any games that I would had I not been wearing an artificial limb," says O. D. Stone, Hanger wearer in Texas. Not all wearers of Hanger Limbs can jump as Mr. Stone does above. But Hanger wearers **can** and **do** walk comfortably, safely, and satisfactorily, and perform everyday activities. Hanger Limbs allow the amputee to return to daily life as a living and working individual.

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**527-29 S. Wells St., Chicago 7, Illinois**
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*The Original Spermicidal Creme*

*No Finer Name in Contraceptives. .*

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*Active ingredients:*
Trioxymethylene 0.04% Sodium Oleate 0.67%

*Prescribed For Over A Decade*

WHITTAKER LABORATORIES, INC.
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Exhausting cough goes...



Beneficial cough reflex stays...

MERCODOL provides prompt, selective relief that doesn't interfere with the cough reflex needed to keep throat passages and bronchioles clear.

This complete, pleasant-tasting prescription contains a *selective* cough-controlling narcotic[1] that doesn't impair the beneficial cough reflex . . . an effective bronchodilator[2] to relax plugged bronchioles . . . an expectorant[3] to liquefy secretions. Remarkably free from nausea, constipation, retention of sputum, and cardiovascular or nervous stimulation.

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THE ANTITUSSIVE SYRUP THAT CONTROLS COUGH—*KEEPS* THE COUGH REFLEX

An exempt narcotic

MERCODOL with DECAPRYN®
for the cough with a specific allergic basis.

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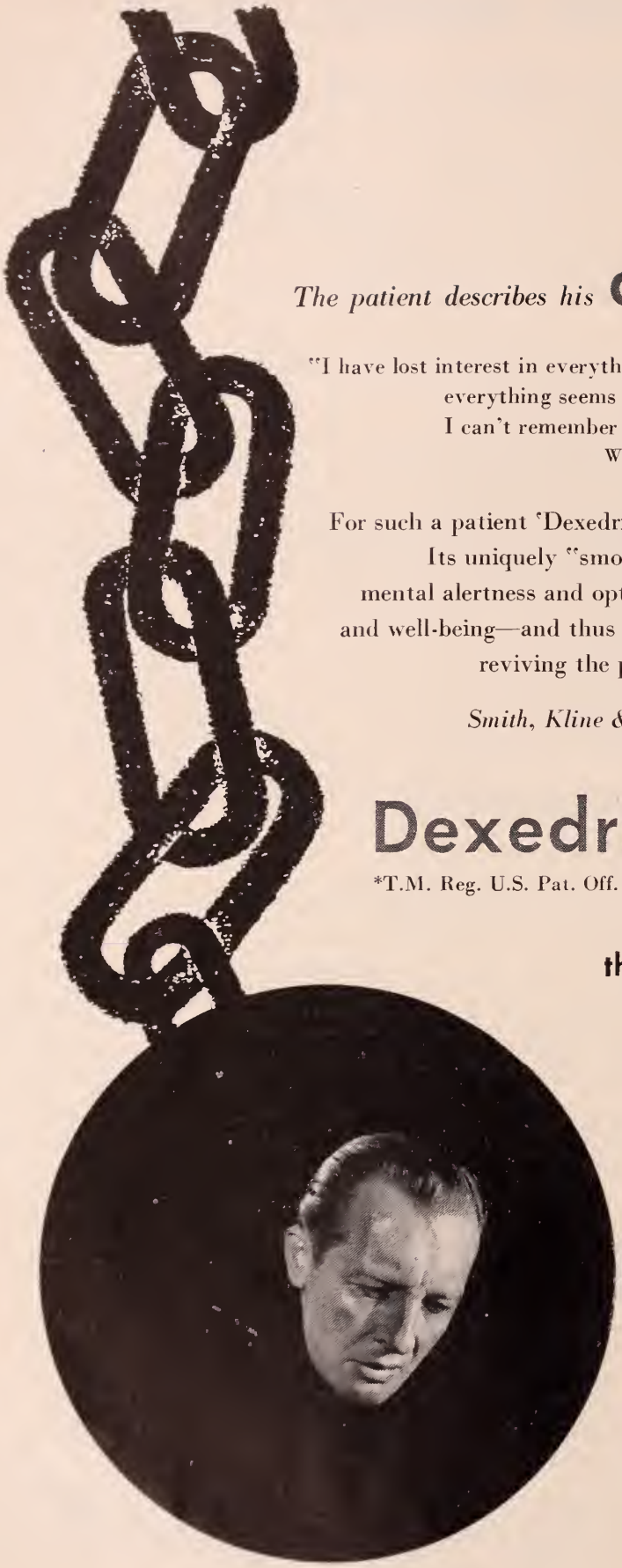
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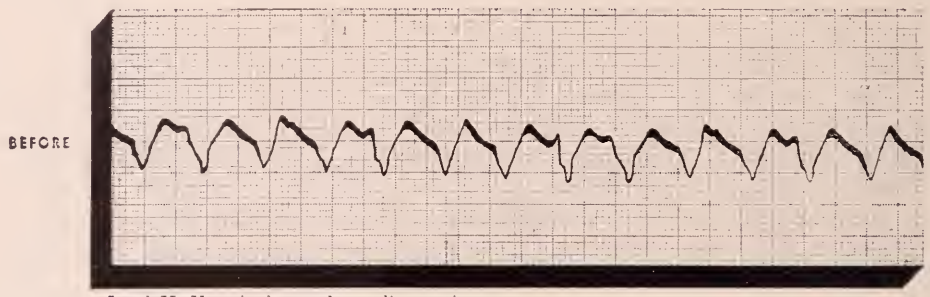
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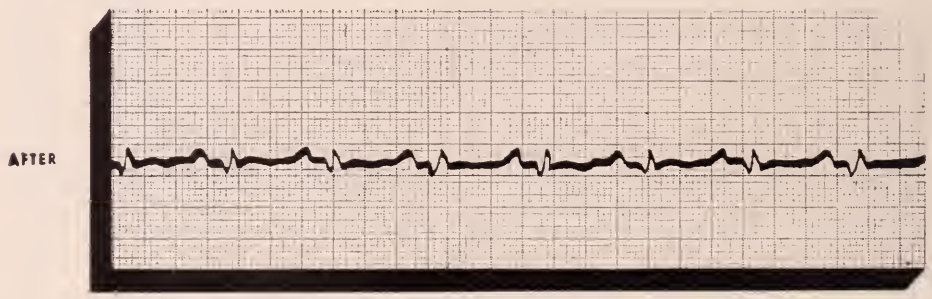
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Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).




Lead II. Normal sinus rhythm after oral Pronestyl therapy.

*Effective in some patients with ventricular tachycardia who failed to respond to quinidine*

## PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*

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**new product brief**

# PRONESTYL *Hydrochloride*

*Squibb Procaine Amide Hydrochloride*

*for the treatment of ventricular arrhythmias*

**What is it?**

Pronestyl Hydrochloride is Squibb procaine amide hydrochloride. Structurally, Pronestyl differs from procaine only by the presence of the amide grouping (.CO.NH.) in Pronestyl where procaine has the ester grouping (.CO.O.)

**How does it act?**

The action of Pronestyl is probably due to a direct depressant action on the ventricular muscle. In auricular arrhythmias, preliminary observations indicate that Pronestyl slows auricular rate but usually does not re-establish normal sinus rhythm. At present, Pronestyl is not recommended in the treatment of auricular arrhythmias.

**When is it indicated?**

In conscious patients, for the treatment of ventricular arrhythmias.

During anesthesia, to correct cardiac arrhythmias.

**What are its advantages in ventricular arrhythmias?**

*As compared with quinidine:* Unlike quinidine, no important toxic symptoms have been reported following the use of Pronestyl orally. In therapeutic dosage, Pronestyl orally does not produce the nausea, vomiting, and diarrhea often caused by quinidine. At high oral dosage, these symptoms may appear

Whereas intravenous administration of quinidine is hazardous and unpredictable, Pronestyl may be given intravenously with relative safety.

Pronestyl has been found effective in some patients who failed to respond to quinidine.

*As compared with procaine:* For arrhythmias, procaine is used only in anesthetized patients because its dose in unanesthetized patients is too toxic for clinical use. Pronestyl can be used in conscious and anesthetized patients.

Intravenously, Pronestyl is much less toxic than procaine. In the recommended intravenous dosage, Pronestyl does not cause the central nervous system stimulation typical of procaine in conscious patients.

Procaine is unstable, being rapidly hydrolyzed in the plasma to para-aminobenzoic acid and diethylaminoethanol. Pronestyl is not affected by the plasma procaine esterase, consequently it is much longer acting than procaine.

Procaine is not used orally because of its instability in the organism; Pronestyl can be used orally and intravenously.

**What are its side effects?**

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of the blood count, urine, liver function, blood pressure, and electrocardiogram. Intravenous administration to patients without ventricular tachycardia produced only a moderate and transient hypotensive effect in about one-third of the subjects. However, during intravenous administration to patients with ventricular tachycardia, a striking hypotensive effect was almost invariably present. This disappeared concurrently with the establishment of a normal rhythm. Further studies are in progress to see whether the drug may be given intravenously over a period of time longer than five minutes so as to revert the ventricular tachycardia without causing hypotension. That this may be possible is indicated by the fact that some episodes of ventricular tachycardia have been successfully treated by oral administration without significant change in blood pressure. Electrocardiographic changes: prolongation of QRS and QT intervals and occasional diminution in voltage of QRS and T waves have occurred.

**What is the dosage?**

IN CONSCIOUS PATIENTS

*For the treatment of ventricular tachycardia.*

ORALLY: 1 Gm. followed by 0.5-1.0 Gm. every four to six hours as indicated.

INTRAVENOUSLY: 200-1000 mg. (2 to 10 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. If marked hypotension occurs, rate of injection should be slowed or stopped.

*For the treatment of runs of ventricular extrasystoles.*

ORALLY: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

*During anesthesia, to correct ventricular arrhythmias.*

INTRAVENOUSLY: 100-500 mg. (1 to 5 cc. Pronestyl Hydrochloride Solution) *Caution – administer no more than 200 mg. (2 cc.) per minute.*

**How is it supplied?**

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.

Pronestyl Hydrochloride Solution, 100 mg per cc., in 10 cc. vials.

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In many patients, mild soft-tissue deformities of the knees or elbows have disappeared within 7 to 10 days. An increase in muscle strength has been reported. The extent of return to normal has been limited, as must be expected, by the degree of permanent pathologic change present.

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*The Stump should be dressed with Stockinet before using VACULIMB*

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CRYSTALLINE

for complications
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in Childhood

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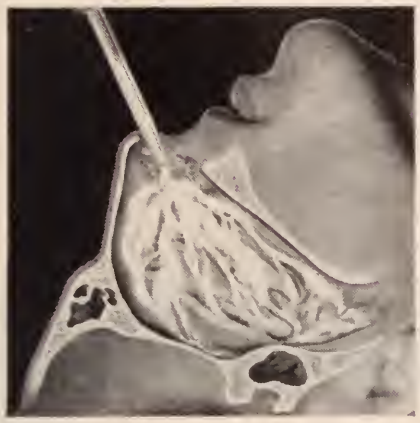
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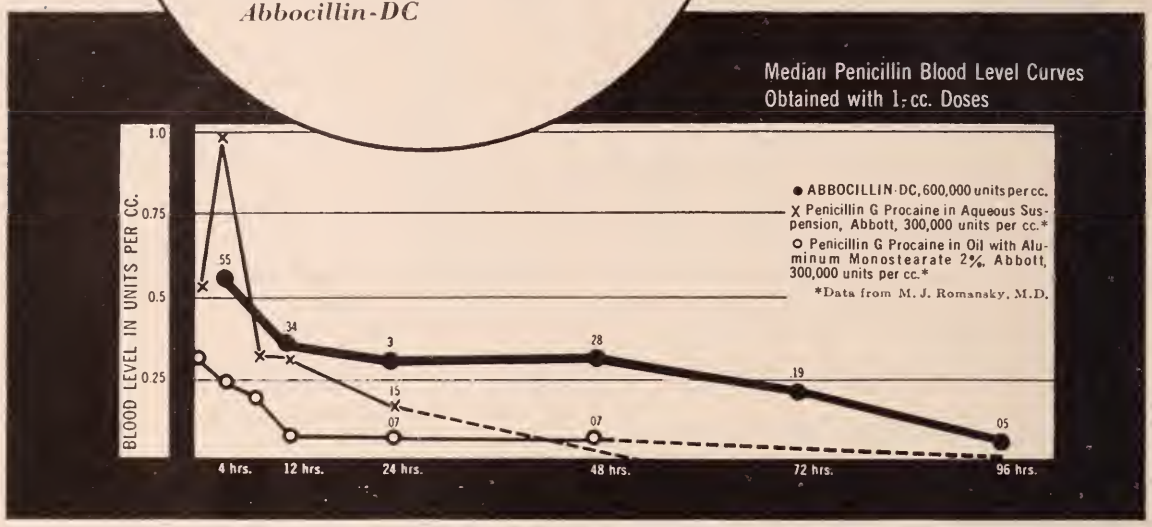
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*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

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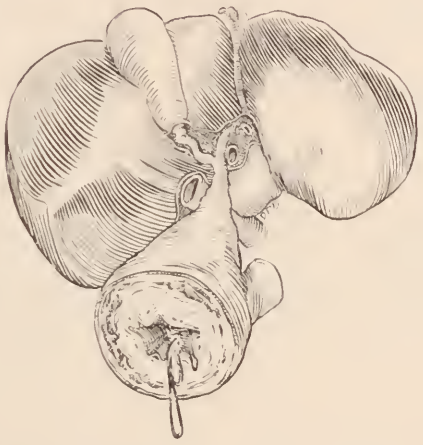
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**NUBILIC** represents the modern trend in the management of inflamed and congested gallbladder and bile ducts.

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**NUBILIC** contains belladonna, which encourages free drainage and relaxes the sphincter of Oddi. This action is further enhanced by the central sedation of phenobarbital.

# NUBILIC

Each Nubilic Tablet contains:

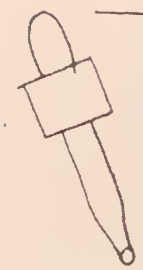
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| Dehydrocholic acid | 0.25 Gm. (3¾ gr.) |
| Phenobarbital | 8 mg. (⅛ gr.) |
| Belladonna | 8 mg. (⅛ gr.) |

Bottles of 25, 50 and 100 tablets

## NUMOTIZINE, Inc.

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Therapeutic penicillin dosage is EASY, PLEASANT with



DROP-CILLIN

50,000 UNITS* IN A DROPPERFUL

Available in 9cc. bottle containing 600,000 units.



DRAM-CILLIN

100,000 UNITS* IN A TEASPOONFUL

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Both with a palatable vanilla flavor.

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## WITH BENZOCAINE

### FOR CONTROL OF LOCAL DISCOMFORT

The clinical efficacy of bacitracin troches has been further expanded by the incorporation of 5 mg. of benzocaine per troche. The local anesthetic action so provided, in addition to the specific antibiotic effect of the bacitracin, makes for a wider field of usefulness in the treatment of pharyngitis, tonsillitis, and gingivitis. These troches remain intact for a prolonged period thereby exerting an extended anesthetic influence and creating high salivary bacitracin levels.

The confection-like chocolate taste of C.S.C. Bacitracin Troches with Benzocaine makes for universal patient acceptance. Their candy-like taste and appearance encourage their continued use by adults as well as by older children.




C. S. C. Bacitracin Troches with Benzocaine are available on prescription through all pharmacies in bottles of 25.

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*Each C.S.C. Bacitracin Troche with Benzocaine contains*
1000 UNITS OF BACITRACIN AND 5 MG. OF BENZOCAINE


Because

*patients can't*

# "SLEEP OFF" *hypertension...*

*prolonged vasodilation should accompany sleep as well as the day's activities. (One more reason why NITRANITOL is the most universally prescribed drug in the management of hypertension.)*

# NITRANITOL®

FOR GRADUAL, PROLONGED, SAFE VASODILATION

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**When sedation is desired.** *Nitranitol with Phenobarbital.* (¼ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

**For extra protection against hazards of capillary fragility.** *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

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*puppy dog,*
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*or paint...*




## *your allergic patients need not suffer*

prolonged distress until a specific allergen is discovered and—if possible—eliminated. Rapid, sustained relief can usually be obtained with BENADRYL, pioneer antihistaminic.

Today, for your convenience and for ease of administration, BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a wider variety of forms than ever before including Kapseals,® Capsules, Elixir and Steri-Vials.®

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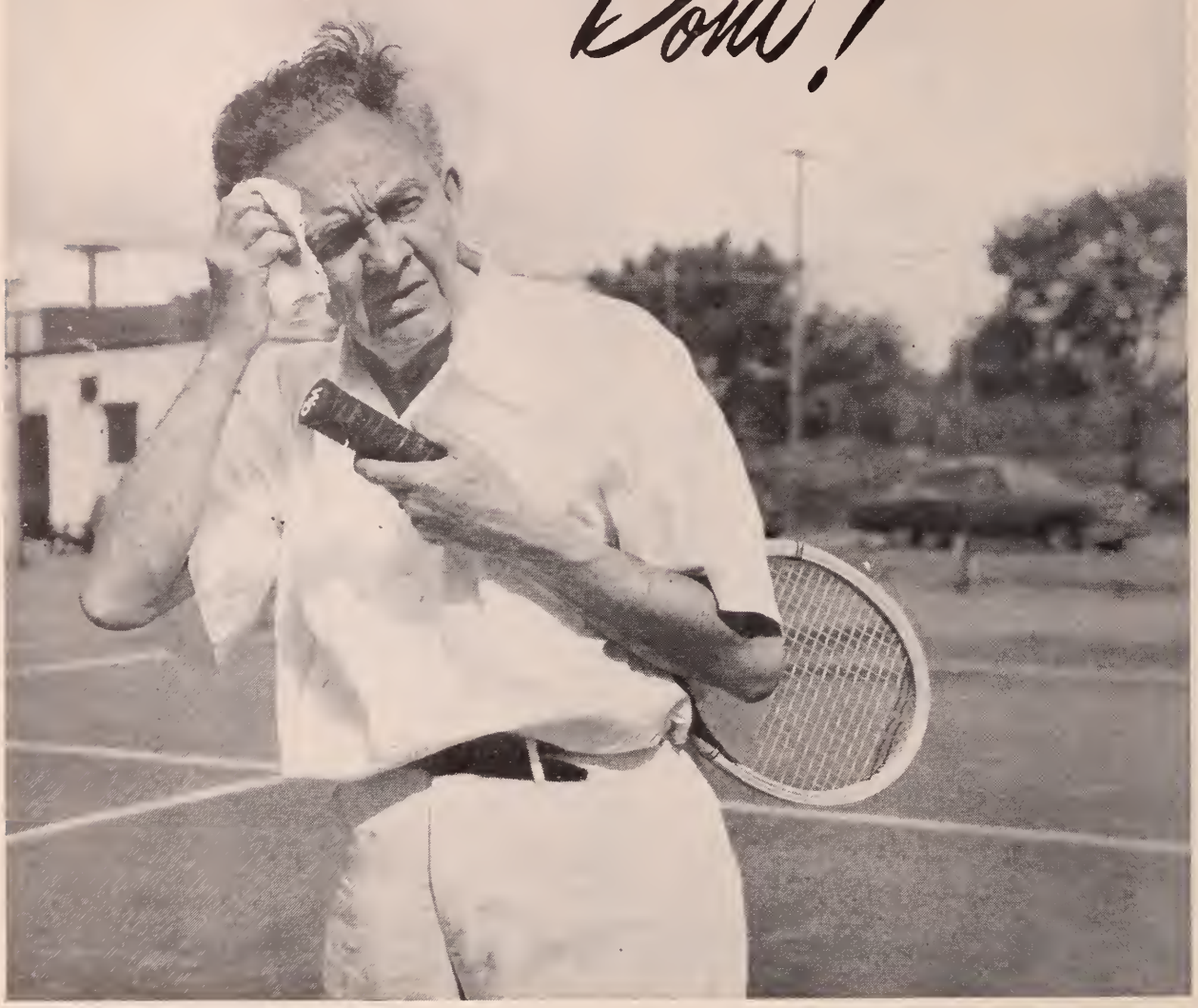
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*Don't!*



In the management of arterial hypertension cultivation of sensible habits of living —avoiding physical and emotional stress —plays an essential role and aids considerably in the stabilization of pressure on a lower level.

For supplementary medication Theominal, the vasodilator, antispasmodic and sedative, is well suited. Theominal exerts a general tranquilizing effect and thus helps to control temperamental outbursts that may induce dangerous vascular crises.

The average dose is 1 Theominal tablet two or three times daily. With improvement the dose may be reduced or omitted periodically. Each tablet contains 5 grains theobromine and ½ grain Luminal.®

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**THEOMINAL®** *for Arterial Hypertension*

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*a new type antihistaminic*

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CHLORCYCLIZINE HYDROCHLORIDE

℞ on prescription only

New because its distinctive chemical component is a piperazine ring instead of the ethylenediamine group on which most antihistaminic compounds have so far been based; greater specificity of action is the result.

The clinical usefulness of 'Perazil' rests on its well marked and prolonged antihistamine action and the fact that only a few patients experience any side reactions: those who do so usually find them mild.

*"The percentage and severity of side reactions was very low. Due to the longer duration of action of 'Perazil', less frequent administration of tablets was necessary".*

*Cullick, L. and Ogden, H. D.: J. South Med. Assn. 43: No. 7, July 1950*

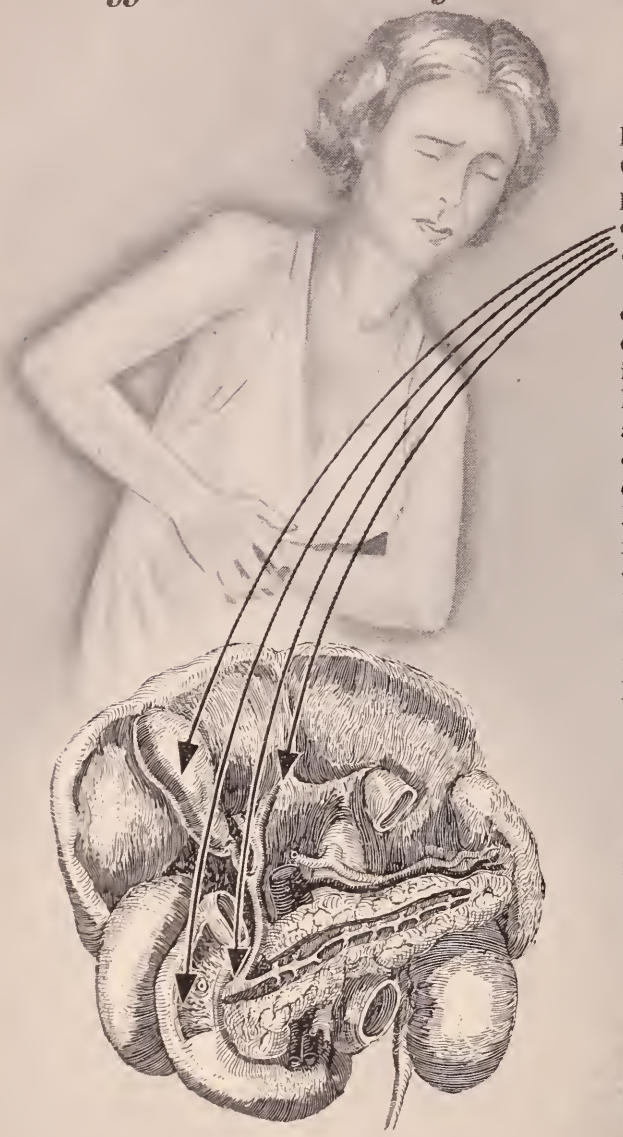
INDICATIONS: Hay fever, vasomotor rhinitis, urticaria, allergic dermatitis and pollen asthma.

DOSAGE: 50 mg. (one product) once or twice daily with water; may be increased if required in severe cases.

PREPARATION: 'Perazil' brand Chlorcyclizine Hydrochloride 50 mg. Each compressed product is scored to facilitate division.

BURROUGHS WELLCOME & CO. (U.S.A.) INC. Tuckahoe 7, N. Y.

# Oxsorbil* *achieves efficient bile flow on a more normal diet*



**In biliary tract disease, OXSORBIL Capsules provide a unit action only possible with a rational combination of choleretic, hydrocholeretic, cholagogue and fat emulsifier.**

**Complete flushing and evacuation of the gall bladder and the biliary ducts are achieved through the integrated actions of extract of ox bile, dehydrocholic, desoxycholic and oleic acids. Since fats are most efficient cholagogues *per se*, they can be incorporated in the diet because the exceptionally efficient fat emulsifier in OXSORBIL Capsules (Sorbitan Monooleate Polyoxyethylene Derivative) permits the patient to tolerate a more normal diet with comfort. Literature available.**

Each Oxsorbil Capsule Contains:

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| Dehydrocholic Acid | ½ grain |
| Desoxycholic Acid | ½ grain |
| Extract of Ox Bile U.S.P. | 1 grain |
| Sorbitan Monooleate Polyoxyethylene Derivative | 2½ grains |
| Oleic Acid U.S.P. | 2¾ grains |

**Oxsorbil**
**CAPSULES**

* OXSORBIL is a trade-mark of Ives-Cameron Company, Inc.

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## COUNCIL ACCEPTED

***new broad-spectrum antibiotic***

***orally effective—well tolerated***

# CRYSTALLINE Terramycin HYDROCHLORIDE

Active against specific organisms in the bacterial, rickettsial and protozoan groups

***Suggested for:*** *acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus and aureus, and other Terramycin-sensitive organisms; brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.*

***Dosage:*** On the basis of findings obtained at over 100 leading medical research centers, 2 to 3 Gm. daily by mouth in divided doses q. 4 or 6 h. is suggested for acute infections.

***Supplied:*** 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25;
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***Pfizer***

*Antibiotic Division*

CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*



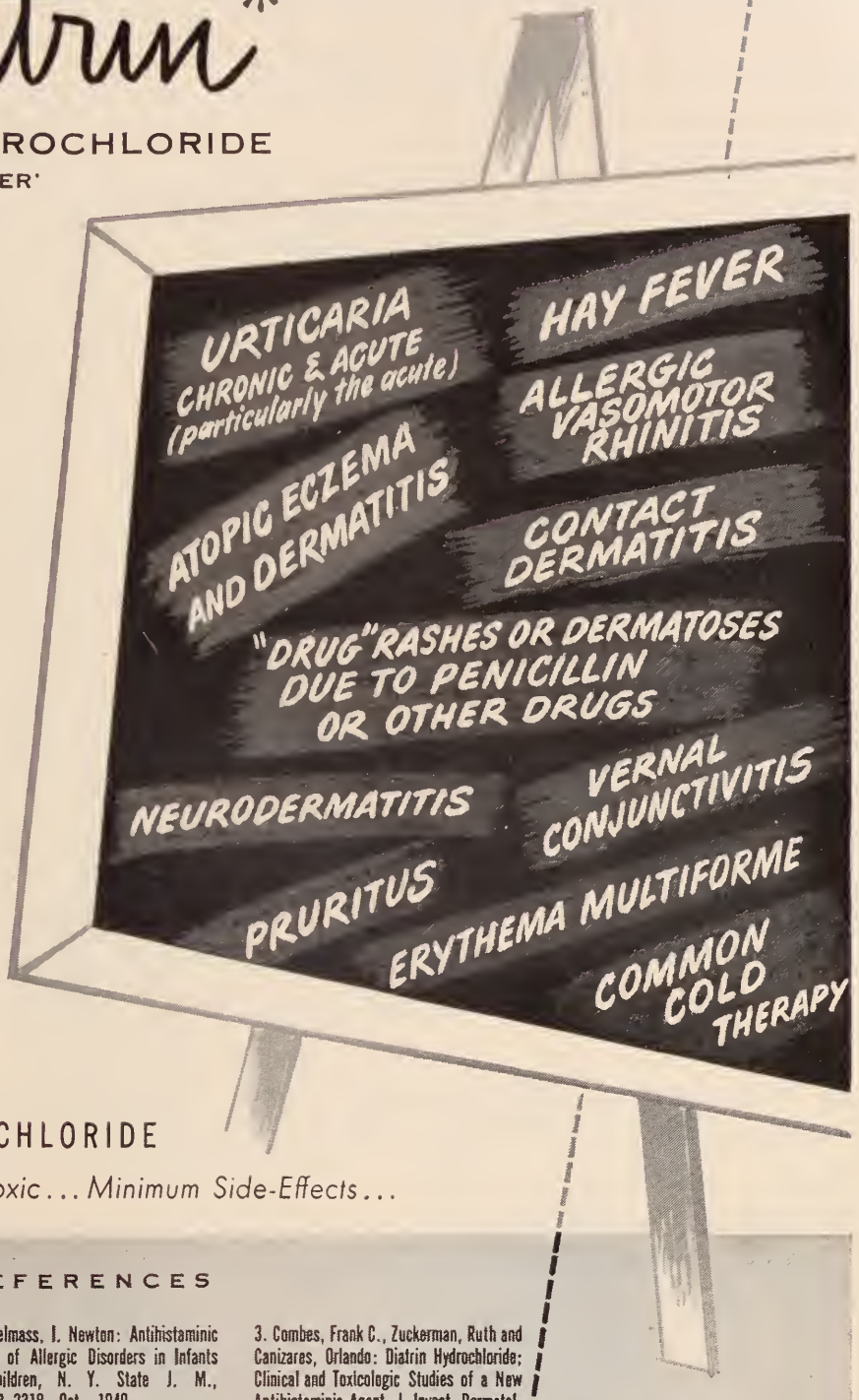

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# WIPE ALLERGIC DISORDERS FROM THE SLATE

**Diatrin*** HYDROCHLORIDE
'WARNER'




**A SUPERIOR**

**ANTIHISTAMINIC OF**

**PROVED VALUE** [1, 2, 3]

DIATRIN* Hydrochloride sugar-coated oral tablets, 50 mg each, are available in bottles of 100 and 1000 tablets.

DIATRIN* HYDROCHLORIDE

*Effective . . . Less Toxic . . . Minimum Side-Effects . . .*

REFERENCES

1. Combes, Frank C., Zuckerman, Ruth and Canizares, Orlando: Diatrin Hydrochloride; a New Antihistaminic Agent for the Treatment of Pruritis and Allergic Dermatoses, Ann. of Allergy, 7:676-678, Sept.-Oct., 1949.

2. Kugelmass, I. Newton: Antihistaminic Therapy of Allergic Disorders in Infants and Children, N. Y. State J. M., 49:2313-2318, Oct., 1949.

3. Combes, Frank C., Zuckerman, Ruth and Canizares, Orlando: Diatrin Hydrochloride; Clinical and Toxicologic Studies of a New Antihistaminic Agent, J. Invest. Dermatol, 13:139-144, Sept., 1949.

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New York Los Angeles St. Louis

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# now

## peptomatic* digestional aid in single tablet form

By developing an entirely new type of enzymatic carrier, literally "a tablet within a tablet," Robins now makes available a triple-enzyme digestant—Entozyme. In *one small specially constructed tablet,* Entozyme "packs" pepsin, pancreatin and bile salts—in such a way that they are released only at the gastro-intestinal level of optimal activity. Thus Entozyme greatly simplifies and makes more effective the treatment of complex digestive disturbances of the gastro-intestinal tract. Clinical studies[1,2,3] have demonstrated the value of Entozyme in such conditions as chronic cholecystitis, chronic duodenal ulcer, acute and chronic pancreatitis and certain postoperative syndromes of the gastro-intestinal tract—in relieving nausea, belching, distention, anorexia, food tolerance, etc.

**FORMULA:** Each specially constructed tablet contains Pancreatin, U.S.P., 300 mg.; Pepsin, N.F., 250 mg.; Bile Salts, 150 mg.

**DOSAGE:** One or two tablets after each meal, or as directed by physician, without crushing or chewing.

**AVAILABLE:** Bottles of 25 and 100.

**REFERENCES:**


1. Kammandel, N. et al.: Awaiting publication.
2. McGavack, T. H. and Klotz, S. D.: Bull. Flower Fifth Ave. Hosp., 9:61, 1946.
3. Weissberg, J., McGavack, T. H. and Boyd, Linn J.: Am. J. Digest. Dis., 15:332, 1948.


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*Ethical Pharmaceuticals of Merit since 1878*



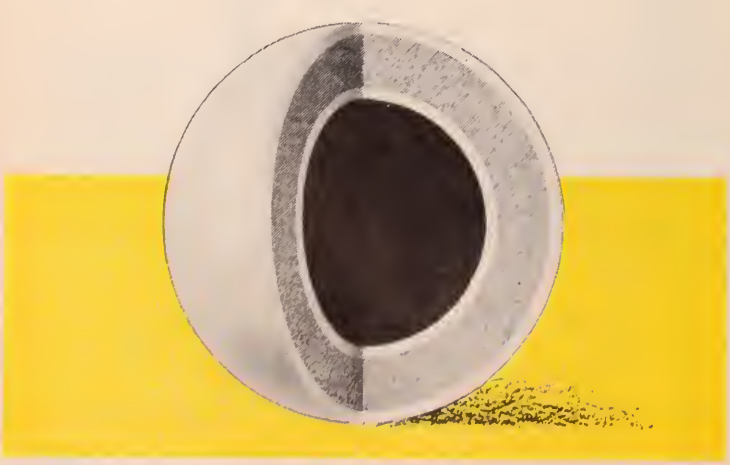
*The "Peptomatic" Tablet*



*Releases pepsin in the st*



*Releases pancreatin and bile salts in the small intestine*



**The "Peptomatic" Tablet—*

a coined word to describe the unique mechanical action of Entozyme Tablet.



The secret of digestional aid
is in the tablet's construction

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**NOW AT LOWER COST**

**Entozyme has been reduced 33⅓% below the original list price.**



# 3,000,000

## HAY FEVER SUFFERERS COME TO YOU FOR RELIEF

*Doctor*

*prescribe*

# CEHISTRA

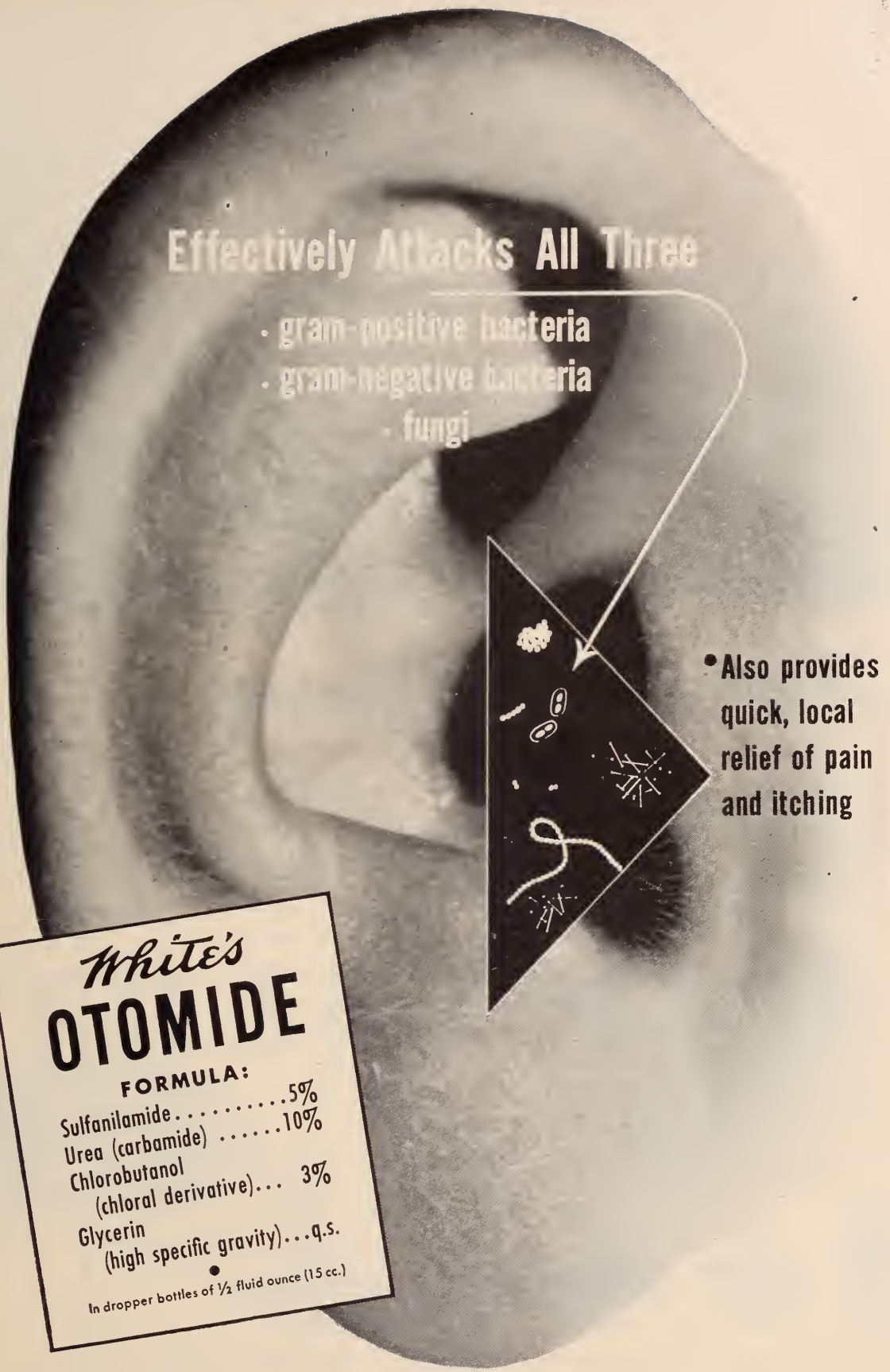
'ORGANON'

Nearly 3,000,000 hay fever sufferers—seven out of every ten who have this distressing malady—come to you and other physicians for relief. You can offer many of your patients prompt, gratifying relief by prescribing Cehistra, for it provides an effective dual attack on hay fever symptoms. Cehistra combines in each effervescent tablet 10 mg. of prophenpyridamine (available as the maleate), one of the most effective antihistaminics available today, and 100 mg. of vitamin C, in itself valuable in helping the defense mechanism, together with 320 mg. (5 grs.) of aspirin and several alkalizers. Cehistra tablets form in water a sparkling, pleasant-tasting, effervescent solution which assures prompt action in the symptomatic relief of most common allergies because the active ingredients are available in complete solution ready for immediate use by the body. You and your patients will be pleased with the therapeutic efficacy, remarkable freedom from untoward effects, and superior palatability of Cehistra.

*Dosage:* One tablet, dissolved in a glass of water, every 3 or 4 hours.

*Availability:* Vials of 10 effervescent tablets. Cehistra is never advertised to the laity.

ORGANON INC. • ORANGE, N. J.




WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N. J.



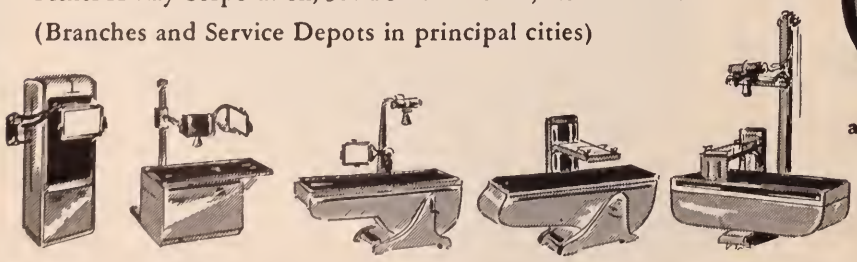
# ...but what's best for me in x-ray?

*"What's best for me in x-ray? What kind, how much?"* The right answer to this question is important... you'll have to live with it... work with it... depend on it. You'd like to keep your x-ray outlay at a minimum: still want to be sure that the equipment you buy can do all the things you'll need to do, now and later.

In short, you're at the point where it would be prudent to call for experienced counsel . . . and your local Picker representative is the man who can offer it to you. He's analyzed and solved dozens of problems like yours. He's primed to *serve* you, not pressured to *sell* you. In your own best interest call in your local Picker man before you come to *any* decision on *any* x-ray apparatus: then judge for yourself.
Picker X-Ray Corporation, 300 Fourth Avenue, New York 10.
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**Picker x-ray**

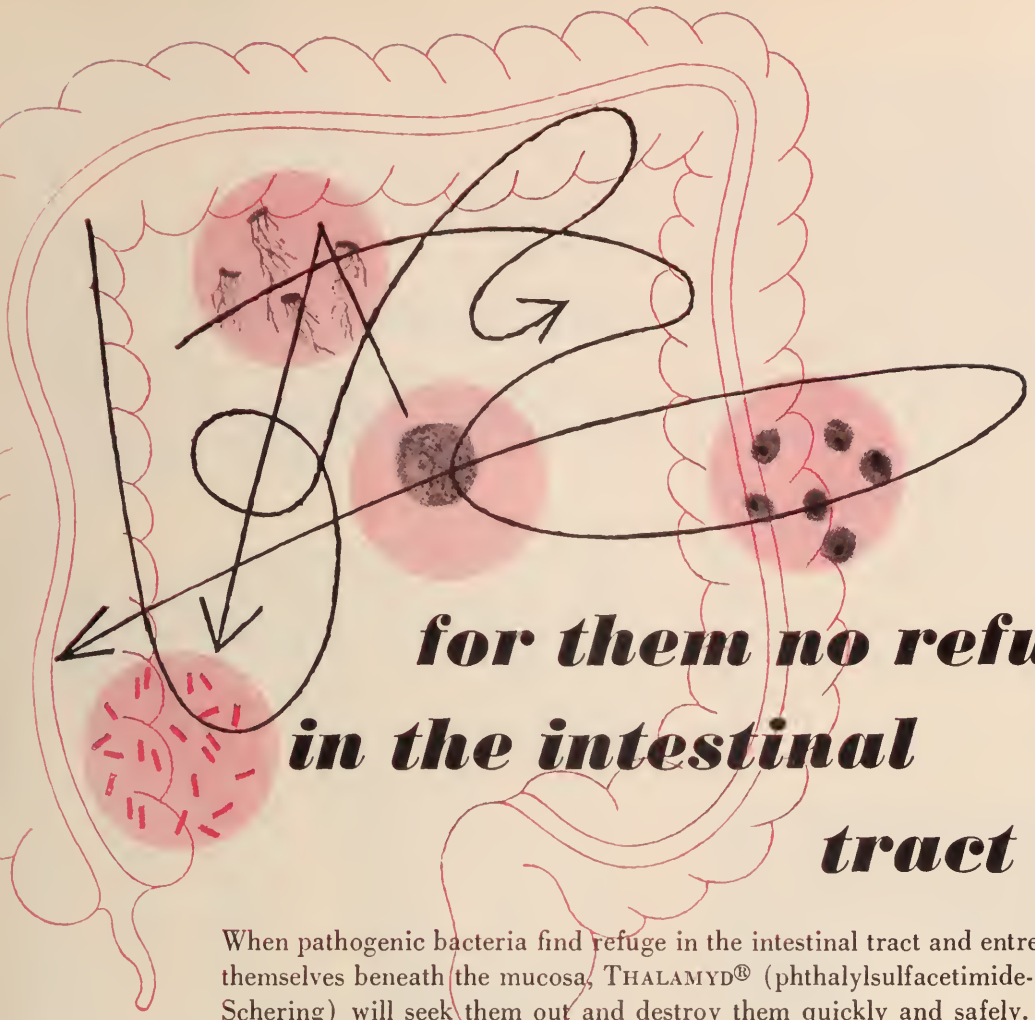
**all you expect . . . and more**



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these are some of the x-ray units in the wide Picker line

**PICKER IN ILLINOIS IS AT 223 W. JACKSON BLVD., CHICAGO 6, (WAbash 2-7475)**



# *for them no refuge in the intestinal tract*

When pathogenic bacteria find refuge in the intestinal tract and entrench themselves beneath the mucosa, THALAMYD® (phthalylsulfacetimide-Schering) will seek them out and destroy them quickly and safely. THALAMYD is highly effective against most gastrointestinal pathogens whether they are within the lumen of the gut or have penetrated the muscularis. A nonabsorbable sulfonamide, THALAMYD is unique in being able to diffuse into the bowel wall, but not into the blood stream.

# THALAMYD

**(Phthalylsulfacetimide)**

More efficient than other nonabsorbable compounds, yet safer than absorbable drugs, THALAMYD is indicated in enteritis, dysentery due to Shigella and other susceptible organisms, ulcerative colitis and preoperative sterilization of the gastrointestinal tract.

**Packaging:** THALAMYD (phthalylsulfacetimide) Tablets 0.5 Gm. Bottles of 100 and 1000 tablets.

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THALAMYD

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# prompt symptomatic relief in hay fever

Your hay-fever patient wants most of all the ability to breathe normally —so that he can eat and enjoy it, sleep and be rested, work and play unhandicapped. For him, you can recommend Benzedrex Inhaler and be virtually sure that it will free him promptly of hay fever's most annoying symptoms.

**Benzedrex Inhaler**
has four outstanding advantages:

1. More rapid vasoconstriction
2. More prolonged vasoconstriction
3. Clean, medicinal odor
4. No excitation or wakefulness

*Smith, Kline & French Laboratories, Philadelphia*

# Benzedrex Inhaler

***the best inhaler ever developed***

*'Benzedrex' T.M. Reg. U.S. Pat. Off.*




## how to avert an obstetrical emergency

There is a measure which prevents
nearly all hemorrhages
associated with childbirth.
Although most deliveries are normal,
a drug which can avert
an unpredictable emergency
is a wise investment in every case.
Consistent prevention
of mishap due to hemorrhage
is assured with the regular use
of 'Ergotrate Maleate'
(Ergonovine Maleate, U.S.P., Lilly).

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Detailed information and literature
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are supplied through your M.S.R.*

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*A 19" x 12" reproduction of this illustration by Joseph Feher is available upon request.*

## · harvest for maternity

In the sun-drenched fields of southwestern Europe, workers gather a fungus growth called ergot. Although derived from a grain disease, it supports maternal health.

Unlike venerable crude extracts of ergot, which are erratic in effect, ergonovine is a pure substance that is uniformly potent. Introduced by the Lilly Laboratories as 'Ergotrate Maleate' (Ergonovine Maleate, U.S.P., Lilly), this reliable oxytocic lessens the complications of childbirth.

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The
# ILLINOIS Medical Journal
Official Journal of the Illinois State Medical Society

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Vol. 98, No. 3 September, 1950

## C. PAUL WHITE, M.D., PRESIDENT-ELECT

C. Paul White, M.D., of Kewanee was unanimously elected as President-Elect at the second session of the House of Delegates of the Illinois State Medical Society on May 25. Doctor White was born and raised at Brooklyn, Illinois, had his preliminary education at the Brooklyn schools, then attended Carthage College and the Western Illinois State Teacher's College in Macomb.

He was graduated from Northwestern University Medical School in 1915, and following his internship at Wesley Memorial Hospital, located in Kewanee, where he has maintained his practice to the present time. Doctor White has long been interested in the affairs of his state and county medical societies, and has been secretary of the Henry County Medical Society over a period of years. For the past several years he has been a member of the Educational Committee of the State Medical Society, has regularly attended all of the committee meetings, and has played an important part in the success of the committee throughout this period. He is a Fellow of The American College of Surgeons.

He was District Governor for the Kiwanis International, serving well in that capacity and making many talks during his term of office throughout the large district. Doctor White has been a member of the House of Delegates of the Illinois State Medical Society for many years, and has always been unusually interested in the many problems before this body, and has had many important assignments given him, all of which have invariably been well cared for.

In his speech of acceptance Doctor White assured the delegates that he would do everything at all times for the best interests of the Society and the medical profession of this state. He stated that in the next year as President-Elect, he would be ready to assist the President, and will support him in every way possible, that the year would be to him one of indoctrination. However, in his year as President, he will ask the support of the membership as a whole, and not be merely a rubber stamp. Those who have known Doctor White over a period of years are definitely of the opinion that he will carry on, as have those presidents who have preceded him in recent years.

## MULTIPHASIC SCREENING

Multiphasic screening is being considered by some of our public health officers as a logical means for the control of chronic diseases. In this process, several tests are done at a single sitting to rule out a variety of diseases. It is a combination of quick and economical procedures in which blood is examined for sugar and syphilis, a chest x-ray is taken to detect tuberculosis, bronchogenic malignancy and cardiac en-

largement; then there are cytologic tests to detect early carcinoma of the cervix.

The public health physician hopes to economize on personnel and equipment by doing all of this under one roof. It is expensive to maintain a laboratory in one part of the town for the sole purpose of doing serological tests and, in another part of town, to do chest x-rays or maintain a cancer detection center. Through centralization the same personnel and facilities will be used and duplication avoided. Blood, for example, is withdrawn only once; half is used for serology and the remainder for blood sugar determination. There is no doubt that this plan would be an economical measure and, if put into extensive use, would uncover many significant diseases which might otherwise go undetected.

Our present tuberculosis and diabetic drives demonstrate this. On the other hand, it is difficult to know where public health stops and private practice begins, or vice versa. In our opinion, it is not a public health measure and only through the greatest stretch of imagination can it be considered the prevention of chronic diseases and therefore preventive or public health medicine. This is food for thought, however, and controversial.

The plan, as it exists, is so limited in scope that other diseases must be added in the future. It is inevitable, therefore, that the program will enlarge. Suggestions have been made already to add hemoglobin determinations, albumin tests of the urine, blood pressure, weight, height, vision and audiometric tests. There is also a plan to include a short history. In our opinion, the plan extends beyond the limits of public health when it performs these functions. This is diagnostic, not preventive medicine.

Many of the wisest physicians of a decade ago complained when the public health officials started their blood testing stations and intensive treatment centers. They saw the handwriting on the wall and considered the move to be an attempt by the government to enter the field of clinical medicine. After all, under the disguise of preventive medicine, blood testing soon was followed by a course of treatment. Public health found rationalization in this move by replying that early treatment prevents late complications. All of this is true but where do we go from here?

The same could be said of diabetes and almost any disease if we consider the flexibility of the word prevention. Is the early detection of heart enlargement a form of preventive medicine? Yes. But the average physician would like to think of prevention as beginning much earlier than this. True, prevention is related more closely to the variations of cause and etiology. It is here that the public health department can be of great help because of its close association with government and lawmaking agencies. Prevention starts earlier. Lung cancer, for example, goes back to smoking or inhaling irritating substances. Why not start here instead of detecting the disease early?

There is a difference and the difference is keenly felt by the practicing physician. After all, he has these facilities at his disposal. The practicing physician has no objection to multiphasic screening, but he believes that it should be done by those who are best equipped to do the job.

Logically, this should be the responsibility of the physician who is in practice and in daily contact with the sick. But we should not be blind to the fact that multiphasic screening can be popular and unless we take the initiative others will. It requires planning and equipment and the sooner we start the better! Public healthers already are beginning to find measures and some claim that the procedure is warranted because the routine periodic examination is too expensive and requires from one half to two hours. They forget that multiphasic screening also will be expensive especially when it includes everything necessary for completeness.

## ELMER L. HENDERSON, M.D., PRESIDENT OF THE A.M.A.

Elmer L. Henderson, M.D., of Louisville, Kentucky, was installed as president of the American Medical Association at the annual meeting held in San Francisco, on the evening of June 27, 1950. For the first time in the history of the A.M.A., the important function of installing a new president was broadcast over a national radio chain.

Louis H. Bauer, M.D., as Chairman of the Board of Trustees, made the introductory remarks, and administered the oath of office to Doctor Henderson, this likewise for the first time. After taking the oath of office, Doctor

Henderson gave the president's address on "The Responsibility of American Medicine." This fine address was published in the July 1 issue of the Journal of the American Medical Association, and it should be read by every physician in this country.

At this same session, all of which went over the nation wide radio chains, Ernest E. Irons, M. D., as the retiring president, gave a short address, which was well presented. Doctor Irons, assuming the office a year previously, has had unusual responsibilities, and has travelled throughout the entire nation during his term of office. We were informed that Doctor Irons in travelling hundreds of thousands of miles in his defense of American medicine, actually made more than 80 addresses during the past year.

Doctor Irons, like Doctor Henderson, assumed the important position as president of the largest medical organization in the world, at the most critical period which any president of the A.M.A. has ever faced. The position of president of the American Medical Association is one which should not be considered too lightly, and in assuming it the incumbent invariably has a busy year ahead of him. Those who have known Elmer Henderson and have observed his many activities for the interests of the medical profession have the utmost confidence in him, and are sure that he too will carry on in a trying year, and do everything humanly possible to aid in the perpetuation of American medicine as a private enterprise.

As an integral part of the American Medical Association, this Society, like all other state and territorial societies and associations, greet the new president, and will give him a definite assurance of their desire to work with him for the common aim of the profession as a whole, to give adequate care to all the people at a cost which they are able to assume, likewise for the best interests of the citizenry, to continue to oppose efforts to make the provision of medical care a function of government.

**Tuberculosis is preventable and eradicable. In the United States it causes one death every nine minutes. Illinois needs 3000 additional sanitarium beds.**

## HISTORY COMMITTEE PROGRESS REPORT

Material for the History of Medicine continues to come in slowly. Recently Dr. W. R. Roberts of Watseka sent in a History of Iroquois County with photographs of a number of early doctors. Dr. James H. Rutledge of Pike County recently sent in a complete list of the practitioners in that county.

Dr. Morris Fishbein is writing a history of medical publications in Illinois. His daughter — the wife of Dr. Morris Friedell — was a member of the Auxiliary committee which accumulated the data regarding these things. It makes a father-daughter team out of this endeavor.

Jack Neal is writing on the legal side of medicine and doctors and the law.

Dr. Oscar Hawkinson is writing the story of neuropsychiatry.

The Committee needs more material from county societies and histories of more counties and county societies.

We are proceeding slowly but inexpensively.

## PROGRESS REPORT ON AMERICAN MEDICINE

### Address of President Ernest E. Irons Before the House of Delegates, American Medical Association, San Francisco, June 26, 1950

Physicians of this nation are deeply concerned with the prevention of sickness and injury of all our fellow citizens. The care of the sick, the prevention of disease and the alleviation of suffering are the center, the impelling motive, the inspiration, around which are built all the activities of the medical profession. The universally recognized accomplishments of medicine by the combined efforts of research and the application of new knowledge in careful and intelligent practice have been attained in a nation of free enterprise and, in the past, sound economy. The problems of medicine are closely integrated with the economic and social conditions of our people. They are mutually interdependent.

The application of science and discovery make possible continuous advances and new achievements in prevention and control of disease —

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better medicine. There are, however, inherent limitations in medicine; physicians cannot create bodily immortality. Death cannot be prevented; it can only be postponed. All that the physician can do about death is to change age and cause. Proponents of nationalized medicine seem to assume that there is some absolute standard of medical practice and talk glibly of "adequate" medical care as if they could set a standard and a limit to medical progress. Medicine is not static. With other men here, I have seen changes in medicine in the past 50 years, during which time what was regarded as good medical practice has become entirely inadequate today. By the very nature of medical progress, it can never attain perfection, because the goal moves ever in advance. One thing is certain, however, you cannot improve medical care simply by setting up a uniform assembly line system — which always has and always will make it worse. Already in England there is now being advertised private insurance to protect against the dangers and delays of government care. This indicates that even in Socialist England the people are finding that they must turn again to private enterprise, to protect themselves against the evils of socialism.

This development in England is so significant that I wish to read a few sentences from an advertisement of the British United Provident Association which appeared in the *London Punch*, May 10, 1950.

"Which would you choose in the event of illness? Private treatment or the General Ward!

"The National Health Service ensures that everyone receives medical and, if necessary, hospital treatment in the event of illness or operation.

"To many people, however, the necessary formalities, the waiting and, finally, treatment in a general ward, are disconcerting both in anticipation and in practice.

"In view of the fact that serious illness or the need for operation so often strikes without warning, it is no more than obvious wisdom to safeguard yourself and your family without delay. . . ."

We as physicians are resolved that the continuation of the marvelous progress in America shall not be thwarted or diverted by the introduction of a foreign ideology which, as in past decades, now elsewhere before our eyes, is destroying the quality of medical care and delaying the correction of obvious faults. We are well aware of the social and humanitarian necessity of provision for the health care of the indigent and the victims of ill fortune whose plight is due to both economic and medical factors. In former days this was accomplished by local communities and more recently by many excellent city and state aid programs, to which physicians already have given personal and professional support. This aid can be supervised best under local administration, and it then can reach the needy without being diluted by the impositions encouraged by socialistic promoters of the welfare state. We already have achieved in this country the best medical care in the world.

Last month we were favored by the pronouncement of a spokesman for the political backers of government medicine to the effect that now they would be pleased to give up the program for compulsory sickness insurance if medicine could offer any other solution for improving the medical care of the nation. This is an official confession of the bankruptcy of the program plaintively described as "so close to the heart" of their political leader. Recent political events have no doubt played some part in recasting Act II of this modern political Comedy of Errors. An intelligent expansion of sound and helpful programs will succeed without unnecessary national legislation. We shall do best by encouraging more individual responsibility, more self help and fewer treacherous governmental crutches, more honest statements of fact and less deliberate deception and playing with the truth, more willingness to work and less national political tinkering.

### OUR MEDICAL AND ECONOMIC PROBLEM

The objectives of medicine and their relation to our entire American economy are now much better understood by the people of this country than at the outset of our educational campaign. Let us review the progress of this critical fight of medicine and of all patriotic groups to defend our America from the external and internal attacks of socialism and its twin, communism. Prior to two years ago the insidious growth of socialistic practices promoted in the name of social and economic welfare had placed businesses, medicine and even legitimate government on the defensive. In this gigantic malignancy a few

ambitions but unscrupulous men did not hesitate to falsify statistic and sow seeds of discontent and distrust, audaciously using the familiar Marxian technic of the "misery of the masses" in a country the people of which are better fed, more prosperous and more productive than in any nation in history.

The subjugation of medicine to political purposes has always been an early objective in the promotion of the socialist welfare state. Nibbling at the personal responsibility, initiative and freedom of the individual by supposedly innocent and superficially attractive welfare measures went on for years without much opposition. Physicians and others interested in the welfare of the public failed to recognize this process of undermining the originally strong pioneer spirit of our citizens. As professional men and as citizens we fail to realize the gravity of this attack on the moral foundations of our country. After the preliminary softening of the national fiber by alleged temporary welfare promises and benefits, the direct attack on medicine was intensified and medicine found itself in the front line in defense not of medicine alone but of the American way of life.

### THE OFFENSIVE

Now, after two years, the real threat of socialism is better understood by our citizens, and physicians together with other patriotic groups are on the offensive. Much of the previous national inertia which affected business and labor groups as well as medicine has been overcome. Thousands of nonmedical citizens and leaders, at first impressed by the false premises of arguments for compulsory sickness insurance now realize its inevitable destructive effects on quality of medical care, on the independence of the American citizen and on the economic stability of the nation. Still others, though now informed, unfortunately hesitate to "lose face" by admitting that they were deceived. Members of the medical and allied professions are better united in understanding and in purpose than ever before and are determined that there shall be no shackling of medicine and no compromise with the evils of socialism.

A vigorous campaign for voluntary insurance by medically sponsored groups and by commercial insurance companies has brought hospital insurance to more than 68 million, and protection against surgical costs to 40 million and for medical costs to 16 to 18 million persons. Sixteen thousand persons are being added daily to those participating in voluntary health insurance plans. Meantime the professional accomplishments of the medical profession in the prevention and cure of disease have proceeded apace with continuing reduction of illness and lowering of death rates. This progress will be still more rapid when we have disposed of this socialist threat to America.

The general public has been made increasingly aware of the dangers of socialized medicine and socialism, and resolutions in opposition to compulsory health insurance and in favor of voluntary health insurance have been adopted by more than 10,000 organizations. More than 6,600 are nonmedical and include farm bureaus, the American Legion, civic and women's clubs, religious groups, insurance groups and other professional organizations. This is indisputable evidence of the disgust of thinking persons across this land, independently of the political parties, for the insidious socialistic programs which will cost the average man more in taxes than he can receive in benefits.

### CONFUSION

A few months ago it became evident that a bill for the nationalization of medicine could not pass this Congress, and so the program of its proponents was changed and an attempt was made to introduce further fragments of socialism by means of small federal contributions to this or that new welfare agency. A number of such bills were introduced carrying almost no financial commitment, obviously intended to set up a pattern — a foot in the door — so that later these little bureaucracies could grow. In other bills it has been proposed to give federal aid to projects which affect many phases of our economic, educational and medical life. Sometimes these proposals are urged on the basis of alleged need and at other times recommended as progressive social projects, often with the disclaimer of any present intent of local interference by government bureaucracy. No mention is made of the Supreme Court decision of 1942, which asserted the right of government "to regulate that which it subsidizes."

The American people would not now accept socialism as a substitute for our American democracy. However, there still is much confu-

sion in the minds of the public and of many physicians as to the importance of the so-called fringe bills. For the past 15 years the American people have been conditioned to the gradual growth of welfare projects not only in medicine but in other fields of attemped economic planning, which historically in other nations have always ended in economic dictatorship. Economic planning and welfare projects have been promoted as devious alternative measures in preference to meeting economic and social difficulties on the basis of individual responsibility and promoted as devious alternative measures in preincentive of each citizen.

Responsibility for the social welfare of our people, in which all physicians as well as public-spirited citizens are deeply interested, has been gradually shifted from the local community and the state to a federal bureaucracy on the fallacious ground that only federal government could take care of exaggerated claims of alleged tremendous gaps in social and medical care. Great advances in medical and social care already made at state and local levels are interfered with by severe taxation of a wasteful federal government which always exacts an excessive brokerage for the support of the ever growing bureaucracy parasitic on each project. Thus the public and the medical profession have been conditioned to progressive steps which tend to remove from group after group of our citizens the necessity of personal effort. This process of softening and regimentation, whether by direct subsidy or by federal loans to small businesses, has been tolerated by this nation more readily following its temporary regimentation by total war.

A welfare measure, superficially attractive and perhaps relatively innocent in itself, forms a precedent; it is then easy to add a further welfare measure on the supposition that it is similar and perhaps complementary to previous legislation. Thus it is not surprising that many physicians and other thoughtful groups find it difficult to determine where such legislation should stop. This difficulty is also encountered by members of Congress who in the past have taken positions of compromise, which no doubt were strategically expedient at the time but which have persisted to plague those who now see the entire economic and social picture more clearly. A number of laws with a socialistic trend were formerly favored by members of the Congress before they had opportunity to think things through.

The only sound and consistent position for American medicine and the American people is that of opposition to any measures related to the progress of the socialist welfare state. Worthy objectives have been habitually used to camouflage national proposals essentially dangerous to our medical, social and economic well-being. These objectives can be attained more safely and effectively by local and state efforts after appropriate thorough education of the public.

The offensive battle of the medical profession, in addition to outspoken opposition to the socialization of medicine and the socialization of America, must include opposition to fringe bills. We must clear our thinking from the muddle in which it has been placed by the insidious growth of welfare measures of the past 15 years, many of which were surreptitiously planned as steps toward socialism. Help for the needy and distressed can be supplied without destroying their individual freedom and subjecting them together with their fellow citizens to slavery of the police welfare state.

The successful program of local and state service to the sick and needy must not be nullified by dominating interference of selfish federal bureaucracies. Programs for preventive medicine must be advanced and not diverted by the destructive effects of socialized medicine on the quality of medical service to the public.

### NATIONAL SOLVENCY

Medicine will flourish and progress only in a sound economy. Our efforts, therefore, must concern not only the interests of good medicine but also the maintenance of free enterprise and solvent finance in American life. We must labor to maintain the personal freedom and initiative of our citizens. Our funds then will be available to help the needy and improve the conditions of other citizens by local measures; citizens will not lose their initiative and sense of personal responsibility to the state. In this national emergency, whether physicians or business men or farmers or laboring men, we must not be guilty of cowardice or unwillingness to stand up and be counted. We shall have to oppose even some of our medical friends who have

been deceived by the rosy red picture of the welfare state.

This is not a partisan political fight; it is a crusade in which every right thinking doctor who values freedom of opportunity, free enterprise and the maintenance of high standards of medical practice must join.

You, the members of this House of Delegates, represent all the states in th Union. It is by your efforts and influence that every doctor can be shown the part which he must play in the present crisis. We as physicians have traditionally shunned political activities. During war physicians have always joined in efforts to save our republic. Now is the time again to come to the rescue of our country, this time to help save it from socialism.

Physicians in every community must accept and take on the responsibilities of citizenship. First they must register and then vote. A survey taken recently disclosed that 13 per cent of physicians in the localities surveyed were not registered; in fact, 22 per cent did not vote. In this respect they are not different from other well meaning and patriotic groups; for example, 26 per cent of bank employees and executives were not registered and 32 per cent did not vote. The same survey revealed similar figures for pharmacists and ministers and for members of chambers of commerce.

We, as physicians, must pause in our practice long enough to inform ourselves of the issues which confront our country. We must realize that the country is being undermined by treacherous proposals initiated in the name of doing good. We must take an active part as citizens in our government. The problem is simply stated: Compulsory health insurance is socialized medicine despite recent frenzied political efforts to escape the issue. To socialize medicine is to socialize America. The effectiveness of our city, county and state aid programs for the needy and indigent, the further development of preventive medicine, the rapidly growing professional and commercial voluntary insurance against the financial hazards of illness, the multitude of fraternal and religious charitable and self-help agencies, must not be jeopardized and ruined by the imposition of deceptive and wasteful socialistic proposals advanced by those who hope to profit politically at the expense of the freedom of the American citizen.

Do we as a people wish to rush down the socialist road after Great Britain? The answer obviously is "no," but we must present forcefully our convictions. We as physicians and citizens shall not relax until, with other patriotic groups in business, on the farm, in the other professions and labor, we shall have rolled back the socialist flood that threatens to engulf our American freedom and our solvency.

As I conclude my year of service as President, may I thank you again for the honor you have done me, for your own efforts in our crusade and, most of all, for your support, which has made a trying and difficult year much easier. Among the compensations have been the cooperation of the general medical profession and the unity of physicians and of other patriotic groups in our fight to maintain freedom of medicine and freedom of America.

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## HYPERTENSION AND THE MIND

I do not hesitate to tell my patients whom I refer for psychiatric study that emotional difficulties are very common in hypertension, either as a causative or aggravating influence or both, and that it is important that they see someone especially trained to unearth these emotional difficulties and to determine to what degree they influence the hypertension. I have yet, after such an explanation, to have a patient refuse to go to a psychiatrist and have yet to hear of one who regretted the consultation. *Excerpt: Hypertention, Edward T. Brading, M.D., Johnson City, Tenn., Journal of the Tennessee State Medical Association, June, 1950.*

# MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chmn., Hubert L. Allen, Carroll Birch, Thomas C. Browning, Roland R. Cross, James Graham, George Halperin, Edwin S. Hamilton, Eugene A. Hamilton, Ford K. Hick, Edwin F. Hirsch, John Mart, Jay McDonald Milligan, Holland Williamson, John R. Wolff.



# The Basic Economics of Obstetrics

There is no lonelier person in the world than that important senior obstetrical resident on the second day following the termination of his residency. The obstetrical ward is still in existence and the new senior resident has just successfully performed his first breech extraction. Our ex-resident's assets consist of his wife, a three months old daughter, a sick mother-in-law, and a shiny new office. He does not have a patient. One week later he is beginning to wonder just how people do become pregnant. Five weeks later it happens, his first maternity patient arrives. The sister of his former interne. He is in business.

Ten years have elapsed and what has happened to our former ex-resident? Here he is now, sleeping in the doctor's room. It is eight a.m., and he has been up all night again; a multipara has just delivered, another girl aborted, and Harry George called him to help with a manual removal of the placenta. He looks pretty tired, because he hasn't had a solid night's sleep in four nights. He doesn't seem to be resting well either; after all he must prepare that paper concerning his research work for the Illinois Medical Journal, a talk on the management of prolonged labor for the County Medical Society, and only three medical meetings to attend this week.

How did this success come about? Our boy had what it takes! Within his soul was the spirit of the good physician. He wanted to help people and he liked to work. His greatest joy was to share in the pleasure of the creation of a new life, and to see the mother return to perfect health. Tragedy only increased his desire to do more, and withal he remained humble, and trusting to faith.

He soon learned that the question of what to charge for his obstetrical services was minor and really insignificant. The value in cold cash depended solely on two factors: the usual fee for such services in his community, and the patient's ability to pay it. This latter was the most important of all. Having a baby was a young person's game, and most young people had as little money as our struggling doctor. But fortunately there were lots of young people, and most did not stop at just having one baby. So the job was merely to attract enough young people to him.

To do this he found that he had to give his

patients that extra something. He became a good listener. He established "rapport," learned all he could about his patients as to how they reacted to both health and disease. He concerned himself about their family problems, their work, their play, their hopes, and of course their fears. He was never in a hurry, and a patient's telephone call was treated as a major event.

During the prenatal course our Osler never frightened his patient. He always acted as if he were sure of himself and suggested an aura of "all is well" or that "with my suggested treatment it soon will be."

During labor he was sympathetic, encouraging, and concerned about relieving pain. He followed the good principles of conservative obstetrics, and at this time his prime concern was the health of both mother and baby.

After delivery he remained interested in the complete welfare of his patient. He did not throw the baby into the arms of the pediatrician, but remained actively concerned. He encouraged postpartum office visits until the patient was completely recovered from her obstetrical event, and then advised yearly examinations.

And all this for a moderate fee well within the patient's budget. His philosophy that it was better to undercharge many patients, than to create a hardship by overcharging one, soon paid off. His fee was always standard to that expected by the community. He explained this question of fee at the first prenatal visit. He learned to trust people just as they trusted him. He stuck to his fee regardless of the nature of the case. He found that patients didn't understand the meaning of complications and extra skill or major obstetrical procedures. They just wanted a baby and a healthy mother and expected to pay a certain fee regardless of the work involved.

So he continued to give service and render skill. And all in a willing and friendly spirit. Patients found it a pleasure to pay his fee promptly and without argument. He was busy delivering babies to people in all walks of life. His practice was large, his knowledge increased, and his love of people blossomed.

He was friendly to all doctors. He gave advice only when asked, yet was always available. When in consultation he remained humble, let his colleague keep in the limelight and governed his fee by the suggestions of the attending doctor.

He realized his duty to other physicians by working with and for his local medical society. He continued to study and advance with his specialty.

He realized his duty to himself. He learned to take advantage of the slack periods on the Stork's assembly line with proper relaxation and vacations with his family, and carefully nurtured both his physical and mental well being.

By practicing such a philosophy our man not only became the good physician, but he maintained this status by continuing to keep his feet on the ground and to wear the same size hat.

Anyone can succeed as well as our ideal would he follow the same basic philosophy. The basis of economics is to supply the demand. And the demand for a good doctor, skillful, honest, and interested in the patient as a human being will always be present. This demand is so great that no socialization will ever replace the desire of the patient to have her own doctor when she needs him. And the good physician will always be there.

# CORRESPONDENCE




## SURGEONS WILL MEET IN CLEVELAND

The Fifteenth Annual Assembly of the United States Chapter of the International College of Surgeons will be held in Cleveland, Ohio, October 31 to November 3, with headquarters at the Cleveland Hotel.

Surgical clinics will be held in several Cleveland hospitals on Monday, October 30. All scientific sessions will be held at the Cleveland Public Auditorium 9:00 a.m. to 5:00 p.m. Tuesday through Friday. A most excellent program has been arranged at which time some of the most prominent surgeons of America, and some foreign speakers, will discuss the current contemporary surgical scene.

Through the courtesy of Smith, Kline and French Laboratories, a fine colored television program of surgical procedures, originating from the St. Vincent's Charity Hospital, Cleveland will be shown daily in the auditorium from 9:00 a.m., to 1:00 p.m. Motion pictures will also be presented each day depicting many of the recent advances in surgery and surgical technique.

One of the highlights of the meeting will be the annual banquet at the Statler Hotel on Thursday evening when America's great surgeon, Dr. Frank Lahey of Boston, will talk on "Some of the Recent Advances in Surgery." Dr Elmer Henderson, President of the American Medical Association, will deliver an address on "The Importance of International Cooperation in Surgery."

Reservations may be secured by writing to the Committee on Hotels, International College of Surgeons, 511 Terminal Tower, Cleveland 13, Ohio. Preliminary programs may be obtained from the central office, 1516 Lake Shore Drive, Chicago 10.

## UROLOGY AWARD

The American Urological Association offers an annual award of $1000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Palmer House, Chicago, Illinois, May 21-24, 1951.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 10, 1951.

## "YOUR MENTAL HOSPITALS" — DISTRIBUTION OF PSYCHOPATHIC PATIENTS

Among the many responsibilities of the Illinois Department of Public Welfare are those concerned with the distrubution of patients from the Psychopathic Hospital of Cook Coun'y to the State hospitals. For several years, the Department has been responsible for the transportation of patients from the Psychopathic Hospital to the four northern State hospitals, that is Chicago, Elgin, Kankakee, and Manteno State hospitals. For this purpose, it has furnished a transportation clerk, nurse, attendants, and clerical personnel to handle the administrative details concerned with this function.

The Cook County Phychopathic Hospital, under the able direction of Dr. V. Urse, receives many thousands of patients, each year, for mental examination and appraisal. Subsequent to completion of their workup, they may be referred to the State mental hospitals or private sanitaria for treatment.

For some time, it has been felt that a better distribution of patients could be obtained if the Department could furnish a psychiatric social worker who would be available to offer her help in this role. As a result of this thinking, effective April, 1950, the Department placed a qualified phychiatric social worker at the Psychopathic Hospital whose main function has been to aid in the equitable distribution of patients. She is assisted not only by the various personnel of the Psychopathic, but there has also been furnished to her a psychiatrist from the Department on a consultant basis. The entire project is under the direct supervision of the Chief Medical Officer of the Department.

In order to relieve the overcrowding of the northern S'ate hospitals, efforts have been made by the worker, to interest relatives of patients, in having them committed to one of the other State hospitals. Since, in recent months, the Jacksonville and East Moline State hospitals have been the least overcrowded, efforts have been made in that direction; and, as a result of this, a good number of patients are now at these two hospitals where they are able to obtain a much better type of care and treatment since these facilities are the least overtaxed. The Department social worker also concerns herself with those patients who are not residents of this state so that these patients can be rapidly processed for their deportation to their state of residence. The entire program is geared with the thought in mind that the patient's welfare is the goal to be kept in mind, and it is felt that the additional service furnished by the Department has been of great help in the distribution of patients to the various state hospitals of the Department.

G. A. Wiltrakis, M.D.
Deputy Director

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## PRESIDENT'S MESSAGE TO THE WOMAN'S AUXILIARY 1950-1951

As we begin ano'her Auxiliary year, may I extend to all Auxiliary members my good wishes and sincere hope that we may all do our full share in meeting the grave problems that face the profession and our very freedom.

As heir to the privilege of serving you, I'm a little awed before the distinguished record of my predecessors, while welcoming the challenge of their high ideals. Please count on me to do everything possible to continue and increase the usefulness of the Woman's Auxiliary to the Illinois State Medical Society. We will, of course, continue our work on the Benevolence Fund, our "Social Security" for all Doctors and their families who may need it. Last year the Auxiliary contributed $5,354, a superlative accomplishment!

Today's Health, formerly Hygeia, is undergoing changes which will make it an even better Health magazine. We are urged by the A.M.A. to double the subscriptions to this periodical. Take it yourself, place gift subscriptions in schools, libraries, beauty shops, and Community Centers. Authentic health information, attractively presented will do much to combat propaganda against the profession.

May I urge all officers to subscribe to the Bulletin: the "work book" of the Auxiliary. It is published four times a year by the Woman's Auxiliary to the A.M.A. and edited by our own Mrs. James P. Simonds of Chicago. It is a veritable store house of information and help.

All these things I can count upon you to do throughout the year. Our biggest task and our greatest responsibility lies just ahead of us, from now until November 7th, namely — To get out the vote.

According to a survey made in Summit County, Ohio, a County, including the industrial city of Akron, it was learned that —

18% of the physicians of the County did not vote in the 1948 election

13% of them were not even registered and, therefore, not eligible to vote

22% of the wives of physicians did not vote — 16% of them were not registered.

This almost unbelievable data uncovered in Ohio has proven an awakening for many States and "get out the vote" campaigns have been successful.

The results of this campaign in Florida are heart warming where it was recognized that every doctor (and his wife) should become a crusading citizen at a time when our American way of life is threatened. They suggest that every doctor —

1. Register the entire family and vote
2. Solicit every doctor in the community to fight in every possible way the socialization of medicine
3. Mobilize all who are affiliated with health activities
4. Finance the activities through collections from his own group

Then the pamphlet from Florida says:

"Without doubt, the most effective single mission doctors can perform in a congressional campaign, in most districts, is a thorough-going letter writing job, beamed to their patients. Personal letters signed by the doctor on his personal letterhead and mailed in his own envelopes."

As your President, I am counting on each of you to help your Medical Society in this campaign. First of all, see that your entire family is eligible to vote, then help with the letter writing and vote checking.

In Illinois the issue is clear — it is no longer "medicine fight for medicine — it is an American citizen's fight against Socialism, which is the "transition stage between Capitalism and Communism."

As your President, I pledge to you my full support and co-operation in all your undertakings.

Mrs. Carl E. Sibilsky, President
Woman's Auxiliary to the
Illinois State Medical Society

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR OCTOBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the October schedule of clinics for physically handicapped children. The Division will conduct 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services:

The October clinics are:

October 4 — Elgin, Sherman Hospital
October 10 — Peoria, St. Francis Hospital
October 10 — E. St. Louis, Christian Welfare Hospital
October 11 — Hinsdale, Hinsdale Sanitarium
October 12 — Springfield, St. Jon's Hospital
October 12 — Elmhurst (Rheumatic Fever), Memorial Hospital of Dupage County
October 12 — Cairo, Public Health Building
October 12 — Glenview, Village Hall
October 13 — Chicago Heights (Rhematic Fever), St. James Hospital
October 17 — Danville, Lake View Hospital
October 17 — Jacksonville, Our Saviour's Hospital
October 18 — Aurora, Copley Hospital
October 19 — Rockford, St. Anthony's Hospital
October 24 — Peoria, St. Francis Hospital
October 25 — Springfield (Cerebral Palsy), Memorial Hospital
October 25 — Chicago Heights, St. James Hospital
October 26 — Normal, Brokaw Hospital
October 26 — Flora, Clay Co. Memorial Hospital
October 26 — Litchfield, St. Francis Hospital

October 27 — Chicago Heights (Rheumatic Fever), St. James Hospital
October 31 — Effingham (Rheumatic Fever), Douglas Township Building
October 31 — Watseka, County Court House

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

## MEETING ON CHILD SAFETY

The American Academy of Pediatrics and the National Safety Council will hold a joint meeting on Tuesday, October 17th, at 8 P.M. in the Grand Ballroom of the Palmer House, Chicago, Ill., to discuss methods of preventing accidents among children. The main objectives of this joint meeting are:

1. To focus national attention on the importance of child safety.
2. To develop practical methods whereby the medical profession and other safety interests can mutually aid in reducing the high accident toll among children.
3. To stimulate research in the cause and prevention of child accidents.

With the conquest of the communicable diseases of children, accidents now represent the leading cause of death and an outstanding cause of disablement and other injuries among children at all ages from 1 to 14. The highest rates are in the preschool and runabout age. Most of these accidents occur in and around the home. In an average year, accidents result in the death of more than 5,000 preschool children between the ages of 1 and 4. This is greater than the number of deaths from diphtheria, which occurred annually in this age group, nearly a quarter of a century ago when this dread disease was considered an outstanding cause of child deaths. Concerted action leading to a reduction of accident mortality and morbidity among children is of timely importance.

The following program is planned for this joint meeting:

ACCIDENTS: CHILDHOOD'S GREATEST HEALTH HAZARD

Presiding as Co-Chairmen:
Edward B. Shaw, M. D.
President of the American Academy of Pediatrics
Ned H. Dearborn
President of the National Safety Council

Organizating for Prevention —
President of the National Safety Council

The Pediatric Approach to Accident Control
a. Through practice —
Harry Dietrich, M.D., Los Angeles
b. Through research —
Rustin McIntosh, M.D., New York, N. Y.

The challenge of Child Accident Prevention —
Dr. Herold C. Hunt
Superintendent of Schools
Chicago, Ill.

## MISSISSIPPI VALLEY MEETING

The 15th Annual Meeting, Mississippi Valley Medical Society will be held at the Elks Club, Springfield, Ill. Sept. 27, 28, 29 under the Presidency of Dr. N. G. Alcock of Iowa City, Ia., Immediate Past-President of the Iowa State Medical Society. Over 30 clinical teachers from the leading medical schools will conduct this post-graduate assembly whose entire program is planned to appeal to general practitioners. No registration fee will be charged and every ethical physician is cordially invited and urged to attend. · The American Medical Writers' Ass'n. will hold their annual meeting at the Elks Club on Sept. 27. Programs of both meetings may be obtained from Harold Swanberg, M.D., Secretary, M.V.M. Society and A.M.W. Association, 209-224 W.C.U. Bldg., Quincy, Ill.

# ORIGINAL ARTICLES



# Convalescent Poliomyelitis

**Robert L. Bennett, M.D.**
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An adequate convalescent care program can be set up only after its objectives are clearly defined and the factors that determine the extent to which the objectives can be achieved are thoroughly appreciated.

## OBJECTIVES

The objectives are so obvious that they need little elaboration: (1) We must salvage all neuromuscular units that remain intact after the invasion of the virus is over as well as those that gradually become physiologically available again as the inflammation in the neuromuscular system quiets down. (2) We must prevent or minimize all musculoskeletal deformities that tend to occur with disuse, faulty muscle balance and excessive strain on weakened segments so that our potential muscle power will not be limited by distortion of bone and joint or by contractures of ligamentous, tendonous or fascial tissues. (3) We must utilize this time of convalescence not only for the purely physical aspects of recovery but also to assist the patient and his family to make an adequate compensation to the eventual functional handicap; the success of our program must eventually be determined by the ability of our patients to return to a normal environment and live happy and expective lives.

## FACTORS

1. *The Site and Extent of Central Nervous System Damage.* This factor is of importance not only because it limits the number of neuromuscular units available for use but also because certain deformities of the skeletal system must follow certain patterns of damage in the nervous system. For example, if a large portion of the nerves that innervate the skeletal muscles of a bodily segment, such as the leg and foot, are destroyed, normal strength and endurance of those muscles can never be obtained regardless of treatment. In a child serious alteration of osseous structure and growth may also occur despite the best of care.

**Presented before the General Assembly, Illinois State Medical Society, 110th Annual Meeting, Springfield, May 24.**

2. *The General Medical Condition of the Patient during the First Few Months after the Acute Illness.* Many patients are so severely involved that their general medical condition prohibits application of convalescent routines that under more favorable circumstances would limit the development of musculoskeletal deformities and faulty patterns of motion. For example, the patient who must be kept in a respirator cannot be cared for adequately and will develop changes in bone, muscle, fascia, joint and periarticular structures that will be, in great part, irreversible regardless of the highest type of available treatment.

3. *The Caliber of Available Care.* The average patient with residual weakness following poliomyelitis is at best a difficult problem in rehabilitation, requiring for optimal end results the combined skills and experiences of the internist or pediatrician, the physiatrist and the orthopedist. Many patients with only minimal involvement who could be expected to recover normal functional capacity with intelligent care develop severe handicaps because of early weight bearing, unrestricted activity and failure of the attending physician to recognize mild muscle imbalance and incipient deformity. It must be stressed that the patient, child or adult, regardless of how mild the residual involvement may seem, must be repeatedly checked to determine the effect of increasing growth, weight and activity on skeletal structures. The tragedies of progressive deformity, such as scoliosis, can be minimized only if responsible periodic examinations of the musculoskeletal system are made for many years after the acute episode.

4. *The Responsibility and Intelligence of the Patient and/or His Parents.* This factor could be included in the third category but it is of such importance that it deserves special attention. For all practical purposes the general personality of the patient and his parents is second only to the skill of the physician in assuring the maximum recovery of functional capacity within the limits set by the pathology of the acute disease. It is, of course, impossible to provide hospital bed space for all patients throughout the entire period of their convalescence, but even if it were it would be inadvisable to do so. Prolonged hospitalization is to be avoided because of the danger of mental stagnation and loss of initiative and self-confidence. Return to normal environment and contact with physically normal people are all-important in the overall rehabilitation program. Under ideal conditions the patient should be hospitalized only until the period of rapid recovery has taken place and the correct patterns of movement consistent with the underlying disease have been established. From then on the long-term program to increase strength and endurance by graduated activity can best be carried out at home. In some instances only modified activity is necessary, but in most a very definite routine of joint mobilization and graduated exercises must be carried out for many months or even years.

## SEVEN STEPS IN OVER-ALL PROGRAM OF CARE

The first step (Figure 1) may at first thought be considered unnecessary in a convalescent program but is included to emphasize that certain convalescent routines may actually endanger the patient's life if initiated too early in the acute or subacute phase or at any phase if carried out without regard for the patient's general medical condition.

The second step in our treatment program is the attempt to prepare the patient for resumption of activity. In a great majority of cases this will mean, first, preparation for long and tedious weeks of muscle reeducation. It is at this point that a program of convalescent care really begins. The three major points in the preparation of any patient for resumption of activity are: (1) relief of pain; (2) release of any tightness in the muscles and joints; (3) support of any bodily segment that is weakened.

It should be readily appreciated that coordinated action of muscle groups acting on any bodily segment is impossible if motion of that segment is limited by pain or by limitation of joint motion. Until this is done we can never fully regain the maximum use of existing myoneural units in any bodily segment. Relief of pain and the release of tightness are accomplished by time plus the use of intelligently prescribed sedatives, heat and passive motion. As in the use of all therapeutic agents the type and frequency of application of heat and motion depend on the reaction of the patient. There is no magical formula to achieve this end by any phase of physical medicine except through the intelli-

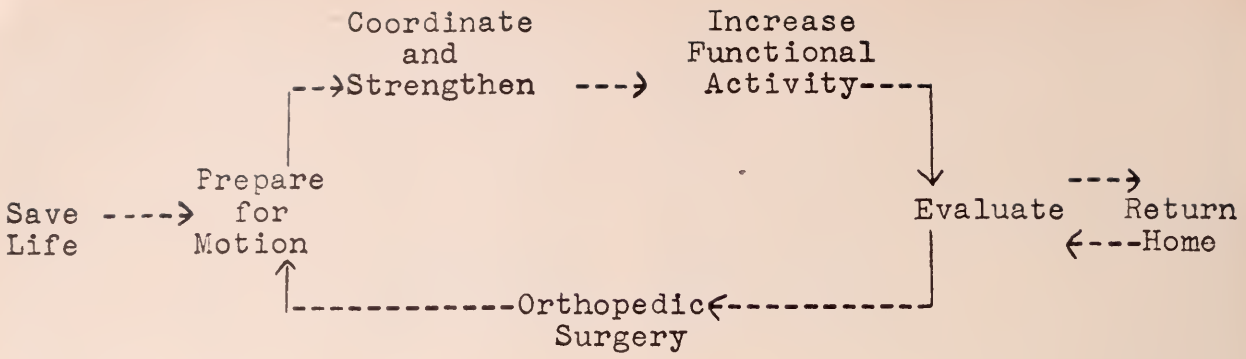



**Figure 1 Seven Steps in Over-All Program of Care**

gence and responsibility of the attending medical personnel. It is equally important in this step that we begin our endeavor to prevent musculoskeletal deformities. Deformities, except for atrophy and weakness following actual denervation, have just one cause: persistent faulty alinement of bodily segments which results in distortion of bones and joints and fibrous contractures of muscular and ligamentous tissue. In this early convalescent stage of poliomyelitis such malalinement results from persistent faulty posture in bed caused by such factors as pain, muscle weakness, faulty beds or the weight of bed clothes on weakened extremities. Therefore, it is of importance not only to preserve normal bodily mechanics and alinement by the early restoration of mobility in muscle and joint as just mentioned but also to prevent this persistent faulty posture by the most effective method possible. An effective support is not only one which holds the segments in proper position but also one which in no way interferes with the other components of early care. It should be quite evident that the type of support will depend on the quality of available medical supervision. Assuming adequate medical supervision is not available, a bivalved plaster cast may be more effective than pillows or sand bags. Under intelligent supervision an orthopedic bed, foot board, properly placed pillows and possibly a light plastic wrist and thumb splint are all the actual equipment needed to prevent deformities at this time.

The third step is to coordinate and strengthen the existing neuromuscular units. Certainly this step is the most important and probably the most difficult one in the entire program. It is in this step that we have made our greatest strides in the treatment of poliomyelitis during the past ten years — not because any outstanding discoveries have been made in functional anatomy or bodily mechanics but primarily because physical medicine has been given an opportunity to use its skill on bodily segments properly prepared for muscle reeducation. It is obvious that the success of this step is absolutely dependent on the thoroughness with which the painless and complete mobility of the segment has been restored. It is a continued source of amazement and gratification to see the extent of functional capacity that can be developed by patients with very little muscle power but highly developed coordination. It must be stressed that coordination and power are not the same. Power without coordination may be disastrous to the patient recovering from poliomyelitis because experience has taught us that all muscles in the involved segments do not recover with the same speed. If, as each of these individual muscles come under voluntary control, no attempt is made to coordinate their use, faulty habit patterns of motion will be built up by the patient with the use of these stronger and more easily available groups to the total exclusion of the weaker and thus less available groups. The development of a truly high degree of coordination in the patient with moderate to severe involvement demands the attention of a highly skilled physical therapist. No athlete ever needed a

coach as badly as these patients need a physical therapist.

It is of the greatest importance to recognize that during this phase of our program all of our routines are based on the hope that sufficient return of muscular strength will occur to permit normal activity in a perfectly normal manner. It is for this reason that normal patterns of movement are stressed until adequate treatment given over a reasonable length of time has revealed the extent of damage to the nervous system and the limits of recovery possible.

It is of the greatest importance to recognize that during this phase of our program all of our routines are based on the hope that sufficient return of muscular strength will occur to permit normal activity in a perfectly normal manner. It is for this reason that normal patterns of movement are stressed until adequate treatment given over a reasonable length of time has revealed the extent of damage to the nervous system and the limits of recovery possible.

How long should we persist in our endeavor to build up the strength of individual muscles by this intensive muscle reeducation? The answer can best be summarized in Figure 2.

Experience has taught us that the recovery of strength in individual muscles or muscle groups

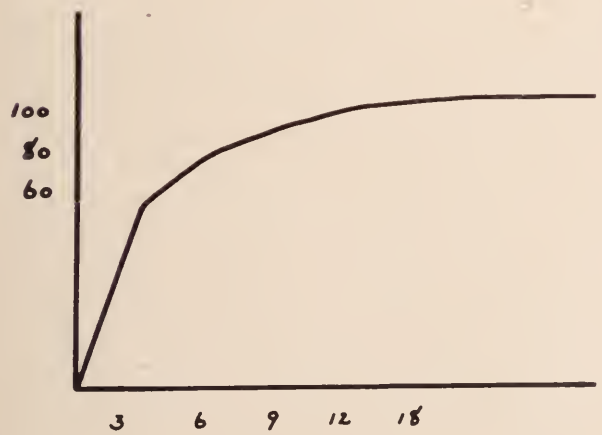



Figure 2

follows a fairly definite curve or pattern. The end of the third month following the acute onset of weakness, a muscle receiving adequate and intelligent treatment has recovered approximately sixty per cent of the total strength that it will ever recover if treated for an indefinite period of time. During the second three months an additional twenty per cent returns for a total of eighty per cent return at the end of the first six months of adequate treatment. After this the recovery rate becomes increasingly slower so that by the end of eighteen months of treatment it can be reasonably assured that no further increase in individual muscle strength can be expected. By applying this recovery rate curve to specific cases it will be seen that a muscle rating of "poor minus" (ten per cent of normal) at the end of a six-month period of treatment can be expected to gain only an additional twenty per cent of that rating or a total of twelve per cent strength even if treated for a year longer. Obviously, twelve per cent of normal strength would mean little or nothing in actual functional value and there would be no justification in treating such a muscle beyond the initial six months time. On the other hand, if a muscle rated "fair plus," or sixty per cent of normal, at the end of the first six months, the possibility of ultimately gaining an additional twenty per cent of that rating (seventy-two per cent of normal) would be well worth working for, particularly if this muscle was one of the important weight-bearing groups.

During this phase the single muscle or muscle group is the unit of treatment. Obviously an accurate grading of these units in the involved segments is essential to the success of muscle reeducation. No muscle test is adequate unless individual muscles and not movements are tested. At the Georgia Warm Springs Foundation detailed test sheets are employed to record the strength of these individual muscles. Test sheets that mix muscles and movements brought about by many muscles are to be condemned.

Apparatus may be necessary to assist the normal actions of muscles at this time, and should be considered a part of the treatment not an admission of defeat. They are applied to allow a more complete return of strength in the full hope that as strength returns they may be discarded.

The fourth step is increasing the actual functional activity of the patient. By the time this step is reached we should be able to determine with a fair degree of accuracy the extent of further improvement that is possible in the

individual patient. Certainly, it will be known by then whether a patient will be able to return to a normal environment and carry on normal activities with normal patterns of motion. It will also be fairly obvious at this time whether it will be necessary to add some type of supportive or assistive apparatus to maintain this activity when the patient returns home. It is during this step that specific functional tests are given the patients to determine their ability to carry out certain activities that are required of them in a normal environment. When existing muscle strength and coordination permits, all of these activities are carried out in a normal manner. If it is obvious that the damage to the motor system of the central nervous system is such that normal patterns of motion can never be achieved, the patient is given the necessary apparatus to support the activity and taught the most effective ways of using this apparatus. If necessary, specially designed assistive types of apparatus are made for the individual patient. It might be perfectly possible for one patient to achieve normal activity without any type of brace, crutch or corset whatsoever. Another patient might be able to achieve the same activity but only by using a long leg walking brace. Another patient, however, might have such severe involvement that walking will never be safe or practical, and that actually teaching him to care for his own personal needs, through the use of specially made splints or feeders, will be his maximum functional capacity.

The fifth step is the attempt to evaluate a patient, not only in terms of what he can do at the present but whether further treatment is necessary to increase his functional capacity and to assure his future security.

All patients regardless of involvement should be completely evaluated by the physiatrist and orthopedist before dismissal from the hospital. On the basis of this evaluation the present status and probable ultimate involvement should be thoroughly discussed with the patient and/or his family. Instructions in all necessary treatment to be continued at home can be given at this time as well as definite instructions in type and extent of activity and the time of the next medical checkup.

The sixth step is usually the return to a normal environment. Before this step is actually made both the patient and his parents should be fully acquainted with the patient's entire problem and the possibility of any change in his status in the future. In a great majority of patients treatment at home must be continued for many months, interspersed with repeated medical examinations to determine the need for additional treatment, either as a means of increasing the patient's functional capacity or perhaps minimizing certain deformities that seem to be occurring.

Thus a patient from the sixth block of a normal environment might return to the fifth block of evaluation and then be sent back into the treatment program, either for increased coordination and strength of muscle effort or for some phase of increased functional activity; or perhaps at this time he will be referred directly to the orthopedist for certain orthopedic procedures

No medical program for the care of the aftereffects of poliomyelitis is complete unless it provides for adequate follow-up if its patients. Maximum return of strength, endurance and functional activity may require years of guided effort. Many deformities will not occur nor existing deformities progress until many years after the onset of the disease. Likewise, many supportive, corrective and assistive orthopedic procedures cannot be carried out with optimum results until patients reach a period of solid bone formation. The doctor must maintain contact with his patient until maximum functional capacity has been obtained and future security established.

The seventh step is that of orthopedic surgery at which time the surgeon endeavors to determine whether certain procedures can increase the patient's ability to function with either greater effectiveness or endurance, but more particularly to determine whether the patient's increasing growth, height, weight and activity can be supported on weakened segments without damage to them. In a great many instances, before any consideration can be given to increased functional capacity and security, the orthopedic surgeon must correct deformities that have occurred during the convalescent period.

The continued physical security of the patient is the most serious responsibility of orthopedic surgery. It is absolutely necessary to foresee the effect of growth, increasing weight, age and activity on weakened bodily segments and to take

adequate precautionary measures when relatively simple surgical procedures will prevent the occurrence of irreversible structural changes. Ideally, surgery should be considered not as a last resort after the damage is done but rather as a means of preventing these tragedies. It is obvious that the results obtained by the orthopedic surgeon depend on the thoroughness of the conservative care during the period of convalescence. Certainly, if fairly normal skeletal alinement and joint mobility have been preserved, the surgeon can do his work more efficiently.

It is essential that we foresee the possibility of later surgical procedures throughout all early phases of convalescence. It is equally important to point out that certain surgical procedures are needed during the convalescent stage. In general, it has been stated that when orthopedic surgery is indicated to correct a deformity, increase functional capacity and assure future security of bodily segments, it should be deferred until the chronic stage or, in children, after bone formation is well advanced. This is only partially true. Relatively simple surgical procedures, such as sectioning of the iliotibial band or heel cord if done early in a convalescent program, often permit restoration of bodily alinement possible in no other way. This not only prevents irreversible and severely handicapping changes from taking place but also permits more effective use of muscle reeducation and functional training.

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# Public Health Aspects of Infantile Paralysis

**E. A. Piszczek, M.D., M.P.H.**
**Chicago**

The importance of infantile paralysis as a public health problem can be realized by the statistical analysis of the reported incidence of the disease for the past three decades. For the ten year period 1920-1929 there were 47,168 reported cases, a yearly average of 4,700 cases. For the decade 1930-1939, 75,271 cases were reported, a yearly average of about 7,500 cases or a 59.5% increase over the previous decade. From the year 1940-1949 a total of 174,886 cases of polio were reported in the United States for a yearly average of 17,500 cases, an increase of 272.3% over the decade of 1920-1929 and an increase of over 133% over the period 1930-1939.

Public health workers are ever alert to the public health problem brought on by the increase in the reported cases of infantile paralysis. They are anxious to assume their great responsibilities, especially during the epidemic waves of the disease that occur in unpredicted cycles in all parts of the country. Illinois has had a three-year cycle incidence of the disease in epidemic proportion.

The public health officer should be interested in three broad fields during an increase in the incidence of polio, namely:

1. Education of the public
2. Education of the physician
3. Provision of treatment facilities in cooperation with other official and voluntary agencies.

*Education Of The Public.* The public should receive the best information available concerning the incidence of poliomyelitis, not only in their own community, but also in other epidemic or near epidemic areas in the country. The public should not invite polio into their family by vacationing in an epidemic area.

The general public dreads infantile paralysis more than any other disease, and yet an intelli-

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gent analysis and understanding of the facts concerning poliomyelitis can allay such anxiety. The public should be aware of the low incidence rate of polio and of the even lower secondary attack rate. They should also know that poliomyelitis does not always result in permanent disablement, that in fact, the incidence rate of polio — particularly paralysis — is very low. Coupled with this, a good health education program for the preparation of the public should bring to their attention the ways and means by which the disease might possibly be prevented, and more specifically those factors which are predisposed to paralytic poliomyelitis.

The following directives should be emphasied to the general public:

*Keep children with their own friends.* Keep them away from strangers or anyone who shows any signs of illness.

*Try not to get over-tired by work, hard play, or travel.* It has been observed that only the good-looking, bright, energetic, ambitious, over-exerting, over-fatiguing type of jitterbug individual who never has time to rest, eat, or sleep is the victim of the disease.

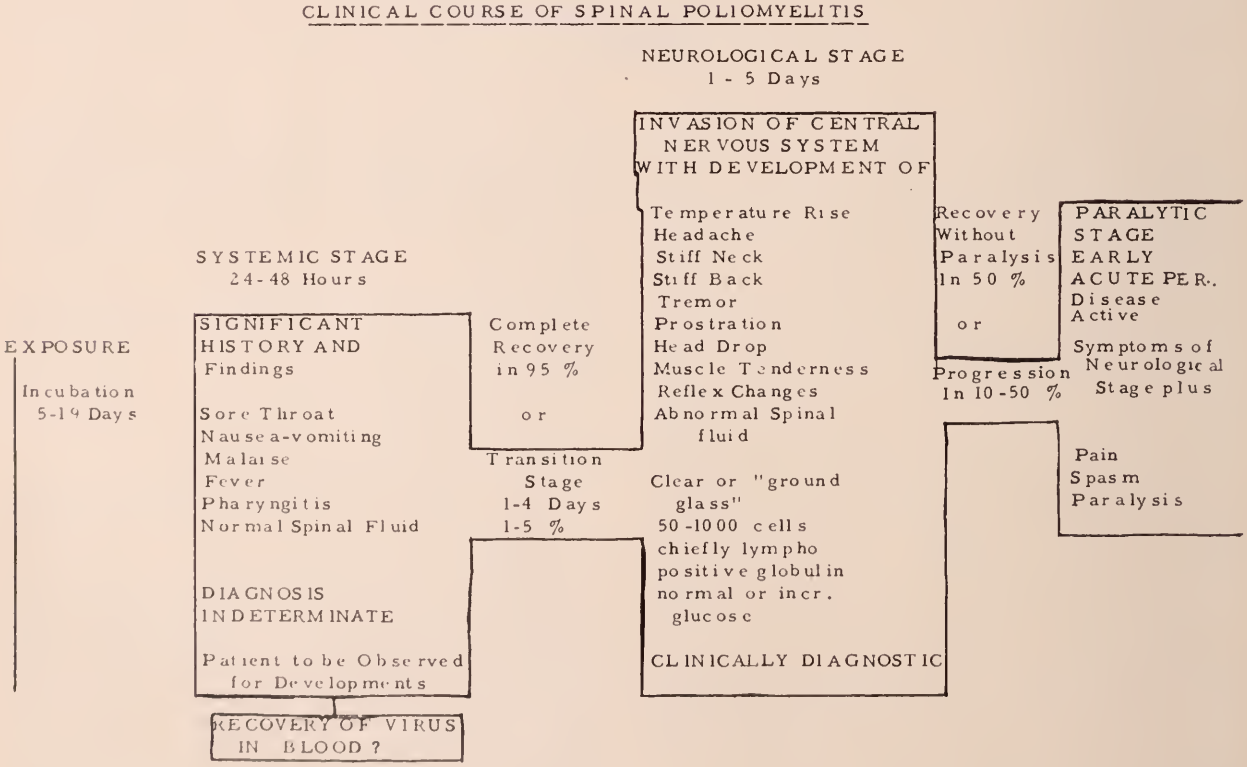
*Keep from getting chilled.* Don't bathe or swim too long in cold water. Take off wet clothes at once. Chilling can lessen the body's resistance to polio.

*Keep clean.* Wash hands carefully before eating and always after using the toilet. Hands may carry the polio infection into the body through the mouth.

*Be careful what you eat and drink.* All persons should be certain that the food they eat and drink has been prepared in a sanitary manner, refrigerated and kept away from flies and insects and other possible sources of contamination.

*Use approved recreational facilities.* Be sure that the swimming pool and other recreational facilities have been inspected and approved by your local health authorities. Never seek recreation or swimming facilities in polluted streams.

*Education Of The Physicians*—In some of our




A COMBINATION OF SPINAL AND BULBAR POLIOMYELITIS MAY OCCUR AS SPINAL-BULBAR (ASCENDING) OR BULBAR-SPINAL (DESCENDING)

**Figure 1**

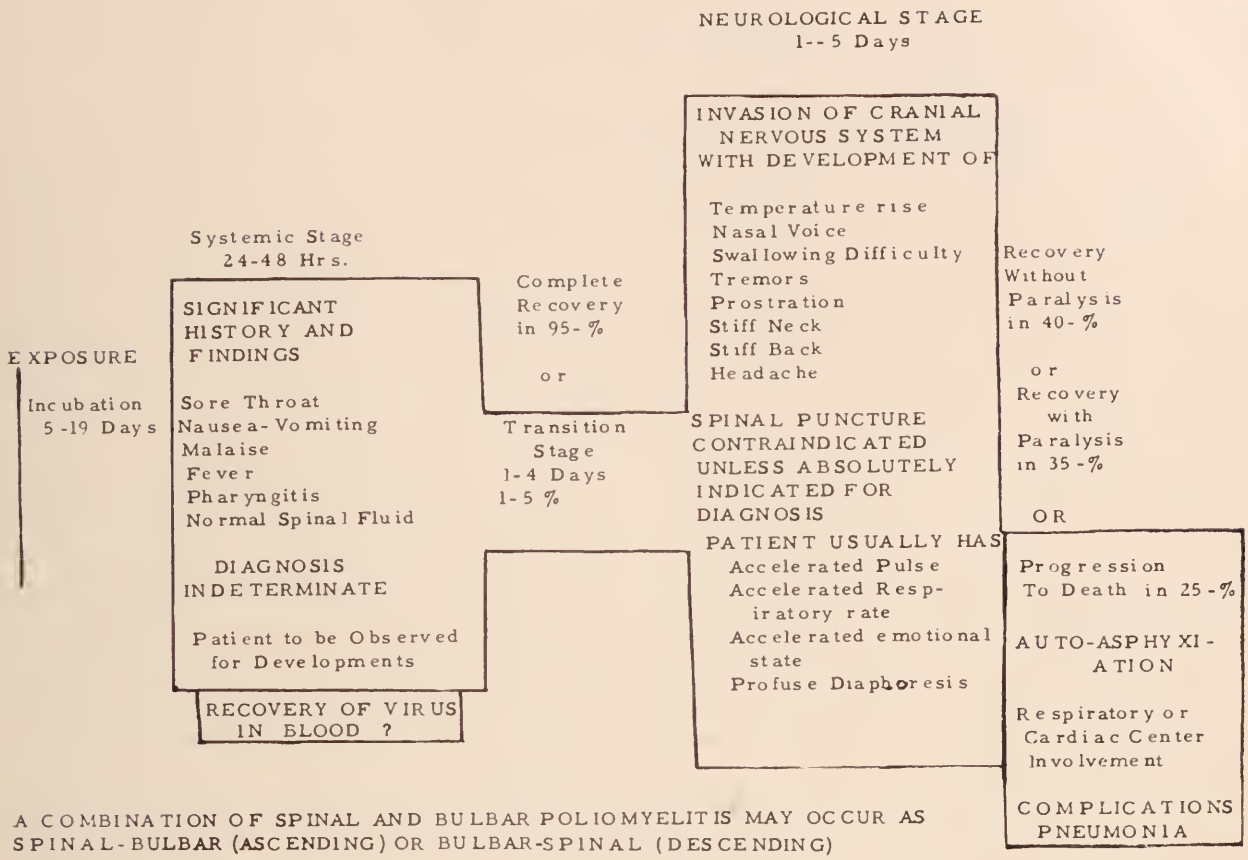



**Figure 2**

urban epidemics in Illinois all of the cases of polio were seen by less than 5% of the practicing physicians, namely the pediatricians and a few of the general practitioners who make home calls. It is with no embarrassment that alert physicians admit the need for current education concerning poliomyelitis.

The health officer is in a position to advise the local physician about the characteristic symptoms which occur in the polio patient. These early symptoms vary from year to year and epidemic to epidemic. (Figure 2) The local physicians should be advised of the incidence of bulbar polio. They should be advised that when a case of bulbar poliomyelitis is diagnosed by a physician that patient should be placed in a position where the head is lower than the rest of the body thus allowing for postural drainage of the saliva from the mouth. It must be realized that the patients with bulbar poliomyelitis cannot swallow, cannot expectorate, cannot cough, and if they are placed in a semi-sitting position and transported in this manner they may aspirate saliva, which at times may cause death. I have seen this unfortunate situation occur on several occasions. These patients should be placed in an ambulance with the head lower than the rest of the body and a suction apparatus or rubber suction syringe should be available to aspirate the mucus out of the mouth if necessary. Transportation of patients with bulbar poliomyelitis over a long distance is not recommended. Excessive speed and the use of the siren which may excite the patient is also not recommended. The smoothest, slowest, road to the hospital should be used. The patient should not be subjected to any strain or agitation and the patient's morale should be maintained at all times.

Spinal puncture. During the polio season and especially in areas where there is an epidemic

any procedure which would excite and aggravate the condition of the patient with bulbar poliomyelitis should be avoided. Spinal puncture is not recommended during the early stage of the disease. At a later time when the patient seems out of danger, if a spinal puncture is desired, it can be done without harm to the patient.

Early diagnosis and the establishment of early and adequate medical care are of paramount importance. Health officers can aid local physicians by providing expert consultation for suspected cases. The local physicians should also be informed daily as to the availability of hospital facilities for the treatment of acute polio.

The family physician should join the health officers in advising the families of victims of poliomyelitis to lead a very lazy life for at least two weeks after exposure to a case of poliomyelitis, as recent figures show that the incidence of multiple cases in the same family has risen sharply in the past decade. Most physicians will remember the fall of 1949 when poliomyelitis struck members of the Yale football team, football practice as well as the scheduled games were cancelled for two weeks.

*Provision Of Treatment Facilities*—With the encouragement of health officials practically every large community has been provided with facilities for the treatment of infantile paralysis by its local hospital by mutual cooperative efforts of the health department, the hospital, the medical profession, and the local chapter of the National Foundation for Infantile Paralysis. In Illinois in 1949 seventy local hospitals admitted polio cases in all stages of disease.

The treatment methods of polio have in recent years undergone radical changes. Changes are being introduced currently. These newer developments in the treatment of infantile paralysis are complex but contribute materially to the comfort of the patient and to improvement in prognosis. It can be definitely stated that the end-results seen in infantile paralysis today are much better than those seen a quarter of a century ago. This has been due largely to the concentration of medical, hospital, nursing and physiotherapeutic effort brought on by the work of the National Foundation for Infantile Paralysis. The cost of the treatment is probably fifty times the cost of twenty-five years ago, but the end-results seen today are worth the price in the prevention of disabling crippling.

## SUMMARY

1. The incidence of poliomyelitis nationally has increased 272.3% over the average expectancy of 20 years ago. Illinois has had a three-year cycle incidence of the disease in epidemic proportions.

2. Public health agencies have a responsibility of educating the general public concerning the incidence, early signs, and preventive aspects of the disease. Early medical attention should be encouraged.

3. Public health agencies should keep the local medical profession advised of the incidence, predominant symptoms, and availability of local hospital beds for the care of the disease.

4. Today communities are providing treatment facilities in local hospitals by cooperative efforts of the health department, the hospital, the medical profession, and the local chapter of the National Foundation for Infantile Paralysis. The problems of polio, despite the large increase in the incidence of the disease, are being met today by these cooperative efforts.

# Problems in Differential Diagnosis of Poliomyelitis

**Herbert M. Woodcock, M.D., Gerald M. Cline, M.D. and Julius B. Richmond, M.D.**

**Chicago and Bloomington**

The variations in the early clinical manifestations of poliomyelitis frequently present diagnostic problems. Increasing interest in the disease and emphasis on early diagnosis has created an awareness among clinicians which has prompted them to "err on the side of safety" by diagnosing poliomyelitis when suggestive symptoms occur. We believe it of interest, therefore, to report our experiences with mistaken presumptive diagnoses in a recent epidemic in this state.

It should be emphasized that it is not our purpose to detract from the importance of early diagnosis. Rather because of its potential gravity, its impact upon parents, and the possibility of inadvertent exposure if an incorrect diagnosis is made, it is highly important that precise criteria be employed in early diagnosis of poliomyelitis. We believe that practicing physicians are interested in learning the fate of patients whom they refer to poliomyelitis diagnostic and treatment centers.

## CLINICAL SUMMARY

The data to be presented were accumulated during the months of July through December of 1949 at St. Joseph's Hospital, Bloomington, Illinois. This hospital was designated as a diagnostic and treatment center for poliomyelitis. A total of 140 patients referred by various physicians in the area were admitted with a tentative diagnosis of poliomyelitis. Of the total number 110, or 78.5%, were found to have poliomyelitis. Thirty, or 21.4%, were found not to have poliomyelitis and of these twenty-three, or 16.4%, were found to present problems of unusual interest. This group of cases forms the basis for this report.

For presentation, the cases are divided into nine general groups (Table 1). The classification has of necessity been arbitrary at times.

From the Department of Pediatrics University of Illinois College of Medicine, Chicago, Illinois.

## DISCUSSION

In view of the extensive literature on poliomyelitis, it is of interest to compare the diagnostic accuracy in the Bloomington epidemic with that of other outbreaks. Gordon[1] over a period of four years at the Herman Kiefer Hospital in Detroit between 1928-31 found that in only one-half of 446 patients admitted with a diagnosis of poliomyelitis was it confirmed. Top and Brosius[2] reporting a larger series of cases from this same hospital gave an error in diagnosis in suspected poliomyelitis of 43.7 percent. The New York epidemic of poliomyelitis in 1931 was reported in detail by Brahdy and Lenarsky[3]. Careful examination indicated that in 113 of the 1123 patients admitted to Willard Parker Hospital the tentative diagnosis of poliomyelitis was not confirmed. During the Kansas epidemic in 1943, Steegman and Stephenson[4] reported on 121 patients referred to the hospital with tentative diagnoses of poliomyelitis. Of this number 74.4% proved to have poliomyelitis. The remaining 25.6% did not have the disease. In Scott's[5] experience during epidemics of poliomyelitis the errors in diagnosis may vary from 4 to 50%. In comparison to these figures, the 21.4% of presumptively incorrect diagnoses in this epidemic represents a good record, especially in view of the relatively large number of physicians making referrals.

The widespread education for the early diagnosis of poliomyelitis has rendered almost any child with a limp, gait disturbance or any loss of function of an extremity a poliomyelitis suspect. It is therefore advisable to emphasize some diagnostic criteria which may eliminate confusion. The following manifestations should suggest that other diagnoses be considered:

1. *Severe pain, localized tenderness, or swelling of affected extremities*

   Swelling of an affected extremity is not usual in poliomyelitis. The presence of pain

TABLE 1
Cases

| General Group and Specific Disease | Symptoms Suggesting Poliomyelitis | Definite Diagnostic Findings |
|---|---|---|
| 1. Acute Infectious Diseases | | |
| 1. Typhoid Fever | 14 year old boy with admission history of headache, stiff neck, spiking fever and vomiting for two days | Diagnosis of typhoid fever suspected on admission. Acute illness, dehydration and fever of 105° with pulse rate 75 not likely in poliomyelitis. Palpable spleen, rose spots on abdomen suggested clinical diagnosis of typhoid fever. Normal cerebrospinal fluid and positive blood culture for E. typhosus confirmed diagnosis. Rapid recovery with chloromycetin therapy |
| 2. Tetanus | 6 year old boy. No history of immunization. No history of injury. Presenting complaints of gradual onset of restlessness, headache, hyperirritability, muscle weakness and one convulsion | Diagnosis of tetanus made on following findings:<br>1. Trismus<br>2. Marked opisthotonos<br>3. Board-like rigidity of abdomen<br>4. Typical facies<br>5. Clonic convulsions<br>6. Profuse diaphoresis<br>Absence of history of injury or no evidence of injury does not exclude diagnosis of tetanus. Recovery after therapy with antitoxin and sedation |
| 3. Tonsillitis Acute Follicular (Streptococcal) | 2 cases (twins 2½ years old) History of older sibling 4 yrs. with recent paralytic poliomyelitis in hospital. These children became ill 3 days following sibling's removal from household. Presenting complaints of fever 103°, vomiting, slight diarrhea, listlessness and cough | Epidemiologically poliomyelitis might be suspected. Physical examination revealed the following:<br>1. Bilateral catarrhal otitis media<br>2. Rhinitis, acute<br>3. Tonsils, enlarged cryptic, studded with yellow exudate, pharynx markedly injected. Moderate cervical adenitis.<br>4. Florid growth hemolytic streptococci cultured.<br>5. Prompt response to penicillin therapy. |
| 4. Rheumatic Fever | 5 year old girl. Entering complaints of headache, stiff neck, low grade fever, sore throat and generalized stiffness for 5 days | Invasive manifestations somewhat prolonged for poliomyelitis. Physical examination indicated:<br>1. Injected pharynx<br>2. Tachycardia — 160<br>3. Erythema marginatum over abdomen<br>4. Slight redness, heat, swelling and tenderness of left knee joint<br>5. Erythrocyte sedimentation rate — 55 mm/hr<br>The fever, tachycardia, rash, acute arthritis and laboratory findings establish the diagnosis of rheumatic fever |
| 5. Lymphadenitis, deep iliac | 8 year old boy. History of apparent weakness of left leg, low grade fever 2 days, pain in inguinal region on left when attempting to move leg | No known exposure. No respiratory or gastrointestinal symptoms. Physical examination:<br>1. Normal upper respiratory tract<br>2. Reflexes all intact<br>3. Rather tender to palpation over the left inguinal region and marked pain when flexing thigh on abdomen<br>4. Infection present on inner aspect of ankle and foot with lymphangitis present on close inspection<br>5. Superficial iliac node palpable on left — slightly tender |

(Continued)

Table 1 (*Continued*)

| | | |
|---|---|---|
| II. Acute Infections of the Central Nervous System | | |
| 1. Pertussis Encephalitis | 5 year old girl. History of 3 siblings in family with whooping cough. Patient had been coughing severely for 1½ weeks. Admitted with following complaints: fever, coma, generalized convulsions | Epidemiology suggestive of complication of pertussis. Physical and laboratory examination:<br>1. Opisthotonos marked<br>2. Bilateral Babinski reflex<br>3. Ankle clonus, sustained, bilateral<br>4. Exaggerated tendon reflexes<br>5. Comatose<br>6. Spinal fluid normal<br>7. White blood count 62000 per cu. mm. with 80% lymphocytes<br>8. Exhibited changing neurological findings gradually becoming decerebrate over period of 2 weeks |
| 2. Meningitis, Bacterial<br>A) meningococcic<br>B) influenzal | A) 6 mo. infant with entering complaints of irritability, fever for 2 days, vomiting 1-2 times with increasing lethargy at time of admission<br>B) Similar history | A) Physical and laboratory examination:<br>1. small petechiae over ankles and wrists<br>2. tense fontanel<br>3. lumbar puncture — 3100 cells, meningococci recovered<br>B) H. Influenzae in spinal fluid. |
| 3. Central Nervous System involvement without infection. Hemiplegia | 10 year old girl. Sudden onset of paralysis of right side of body. No previous febrile illness, slight headache, n convulsions | Lack of history of infection. Physical and laboratory examination:<br>1. blood pressure 230/160<br>2. enlarged heart<br>3. urinary findings, occasional rbc, casts and albumen, low specific gravity<br>4. evidence of wasting<br>5. lumbar puncture normal<br>Findings consistent with chronic glomerulonephritis |
| III. Metabolic Disorders | | |
| 1. Diabetic coma 2 cases<br>A) age 10<br>B) age 5 | Both cases entered in deep coma and acidosis. No previous diabetic history. Both had had acute upper respiratory infections prior to admission. Admitted as cases of possible bulbar poliomyelitis | Physical and laboratory examination:<br>1. Kussmaul respirations. No evident resp. paralysis<br>2. Acetone odor to breath<br>3. Reflexes all hypoactive<br>4. Marked dehydration<br>5. Blood sugar A) 390 B) 600<br>Glycosuria marked. Acetone and diacetic and tests of urine 4 plus. Both responded to diabetic management |
| IV. Allergic Conditions | | |
| 1. Bronchial Asthma | 6 year old boy entered as possible bulbar poliomyelitis. Complaints of "chest cold" for 3-4 days, cough, slight fever, and day of entry he developed rapid, difficult breathing and general malaise | Physical examination:<br>1. Evident wheezing and difficult and prolonged expirations<br>2. Dramatic response to epinephrine |
| V. Poisons (Household) | | |
| 1. D.D.T. Intoxication | 6 year old boy entered with history of having become ill late in afternoon after assisting father in DDT distribution about farm. Child semi-comatose, vomited 3-4 times, was seen to "twitch" 2-3 times on way to hospital | In view of history, DDT intoxication was suspected. Physical and laboratory examination:<br>1. Semi-comatose<br>2. Reflexes all intact<br>3. Moderate dehydration<br>4. Normal cerebrospinal fluid<br>Recovered after 24 hrs. observation with fluid administration |

(*Continued*)

Table 1 (*Continued*)

| | | |
|---|---|---|
| VI. Myopathies | | |
| 1. Amyotonia congenita | 2 month old infant entered because of high fever, cough, vomiting. Infant seemed limp. Mother stated this child was never as active as other 2 siblings | History suggestive of illness antedating present illness. Physical and laboratory examination:<br>1. Rhinitis<br>2. Dullness over right mid. and lower lobes with rales<br>3. Absent tendon reflexes generally, Babinski negative<br>4. Poor muscle tone; very flaccid<br>5. Weak cry<br>6. Rapid respirations<br>No response to therapy; death ensued |
| VII. Acute Myositis | | |
| | 16 year old male. History of sudden pain in right shoulder accompanied by tenderness and some limitation of motion. Afebrile; no previous illness. Did heavy labor | Physical examination<br>1. Point tenderness over deltoid muscle<br>2. No other findings<br>3. Afebrile<br>4. Lumbar puncture revealed normal cerebrospinal fluid |
| VIII. Psychological and Emotional Problems | | |
| 1. Cyclic vomiting<br>2 cases<br>Both case histories similar | 5 year old boy — an only child — entered with history of severe, persistent vomiting of 36 hours duration. No fever, no recent illness. Had had one attack 6 months previously | Physical and laboratory examination revealed only mild dehydration. Recovery with glucose and sedative therapy |
| 2. Hysteria<br>2 cases<br>A) 10 year old girl<br>B) 12 year old girl | A) Simulated paralysis of right leg. History of best girl friend being stricken with poliomyelitis and confined to hospital. Patient's attack followed shortly. No previous infection or illness<br><br>B) Simulated paralysis of left arm. Sibling in hospital with paralytic poliomyelitis | A) History suggestive of emotional instability. Obviously anxious child. Full range of motion of limb involved, reflexes intact. No muscle spasm; refused to walk on right lower extremity. Lumbar puncture: normal cerebrospinal fluid. Improved with reassurance<br><br>B) No abnormal findings in involved limb. Considerable anxiety over sibling. Lumbar puncture: normal cerebrospinal fluid |
| IX. Miscellaneous | | |
| 1. Fractures | 6 day old infant. Born of mother who died of fulminating poliomyelitis 7 days after delivery. Complaint of infant not moving the left leg since birth and of crying and irritability when leg moved. No fever | History suggestive of poliomyelitis. Physical and laboratory findings:<br>1. Normal newborn except for failure to utilize left leg<br>2. Careful examination revealed crepitation, induration and tenderness over mid-thigh region.<br>3. X-rays revealed fracture of femur |
| 2. Tick paralysis | Previously well 7 year old child with rapid onset of stumbling, inability to balance well and headache. Fever 102°. | Unusual onset for poliomyelitis. Physical and laboratory examination:<br>1. Flaccid lower extremities<br>2. Slight stiffness of neck<br>3. Absence of fever<br>4. Lumbar puncture: normal cerebrospinal fluid<br>5. Enlarged tick (Variabolis) found base of neck — removed with rapid recovery |
| 3. Dilantin intoxication | 5 year old male — entered with complaint of ataxia of 2 days duration | History of convulsions. Receiving dilantin therapy. Total daily dose 4 days prior to admission of 8-10 grains. Physical examination revealed no abnormalities. Symptoms disappeared on discontinuance of drug. |

and swelling may suggest: early osteomyelitis, bursitis, acute rheumatic fever, pyogenic arthritis, cellulitis, or acute myositis.

Examples in cases presented: Fracture, acute rheumatic fever, and acute myositis.

2. *A well-marked lymphadenitis or other lymph node enlargement*

When noticeable and painful enlargement of the lymph nodes is present, the following merit consideration: Acute respiratory infection, infectious mononucleosis, peritonsillar or retropharyngeal abscess, tuberculous adenitis, lymphoblastoma and leukemia.

Examples in cases presented: Acute follicular tonsillitis, inguinal lymphadenitis.

3. *A high fever, particularly of a septic nature*

The temperature in poliomyelitis is usually only moderately elevated. The average duration of fever was 4.8 days in a recent Illinois epidemic[6]. A fever curve suggestive of sepsis or localized infection merits consideration of the following: Typhoid fever, pyelonephritis, brucellosis, sub-acute bacterial endocarditis, sinusitis, and otitis media.

Examples in cases presented: Typhoid fever.

4. *A critically ill, irrational or comatose patient*

This is uncommon in poliomyelitis unless *hypoxia* is present. These findings suggest: Meningitis, cerebral hemorrhage or thrombosis, diabetic coma, cerebral manifestations of acute nephritis.

Examples in cases presented: Meningitis, typhoid fever, tetanus, diabetic coma, and glomerulonephritis.

5. *Marked dehydration*

Most poliomyelitis patients are not significantly dehydrated. Dehydration should suggest diabetic acidosis, typhoid fever, bacillary dysentery or other diseases associated with vomiting and diarrhea.

Examples in cases presented: Cyclic vomiting, diabetic acidosis and typhoid fever.

6. *Convulsions*

Convulsions are unusual in poliomyelitis patients. Convulsions may be encountered in infants and small children with an acute onset of poliomyelitis. More commonly observed in tetanus, tetany, epilepsy and acute febrile states.

Examples in cases presented: Tetanus

7. *Prolonged illness with subsequent paralysis and regional sensory changes*

There may be transient hyperesthesias in poliomyelitis but there are no well defined sensory changes. These manifestations may suggest: Post-diphtheritic paralysis or lead poisoning with peripheral neuritis.

8. *Upper motor neurone lesion*

The presence of upper motor neurone signs and symptoms practically eliminates poliomyelitis with the exception of the unusual cortical type. These manifestations suggest: Brain tumor, cerebral vascular accidents and encephalitis.

Examples in cases presented: Pertussis encephalitis and hemiplegia.

9. *Ataxia*

The presence of this finding should lead one to consider brain tumor, multiple sclerosis, common poisonings, and tick paralysis.

Examples in cases presented: Tick paralysis and dilantin intoxication.

The relatively nonspecific nature of the early manifestations and the absence of a specific diagnostic test results in a confusion with a wide variety of disorders. From our experiences and from the literature, a listing of disorders which have been confused with poliomyelitis has been compiled in Table II.

In recent years several interesting problems of differential diagnosis have been emphasized. The differentiation of poliomyelitis from acute infectious polyneuritis (Guillain-Barre syndrome) has been discussed by de Sanctis[7]. The favorable prognosis in the latter disorder accentuates the importance of an accurate diagnosis. The relative symmetry of paresis, the characteristic albuminocytologic dissociation in the cerebrospinal fluid, and the lack of history of an acute infectious onset suggest the Guillain-Barre syndrome.

Paul[8] has presented a study of a group of patients who were admitted to the University of Iowa Hospitals with a tentative diagnosis of poliomyelitis. Careful study did not confirm the diagnosis. The clinical course was that of

TABLE 2
DISEASES WHICH HAVE BEEN CONFUSED WITH POLIOMYELITIS

1. Nasopharyngitis
2. Follicular tonsillitis
3. Sinusitis, Acute
4. Mastoiditis, Acute
5. Otitis media
6. Influenza
7. Pneumonia (Viral, Bacterial)
8. Measles
9. Mumps
10. Scarlet fever
11. Whooping cough
12. Endocarditis (Sub-acute and Acute)
13. Rheumatic fever
14. Typhoid fever
15. Bacillary dysentery
16. Gastro-enteritis, Acute
17. Syphilis, congenital
18. Pyelonephritis
19. Nephritis, Acute
20. Trichinosis
21. Osteomyelitis
22. Torticollis
23. Exanthem subitum
24. Tuberculosis, Acute miliary
25. Cerebral Thrombosis
26. Abscess
    a) Retropharyngeal
    b) Cervical
    c) Intra-spinal
    d) Brain
    e) Inguinal
27. Epilepsy
28. Herpes Zoster
29. Tetanus
30. Infectious Mononucleosis
31. Rabies
32. Malaria, cerebral
33. Serum sickness
34. Vaccination — Post (Encephalitis)
35. Appendicitis, Acute
36. Scurvy
37. Rickets
38. Fractures
39. Suppurative Arthritis
40. Traumatic Arthritis
41. Leukemia
42. Post-Diphtheritic Neuritis
43. Lead poisoning
44. Acute multiple sclerosis
45. Acute myositis
46. Amyotrophic lateral sclerosis
47. Hysteria
48. Bronchial Asthma
49. Bell's Palsy
50. Transverse Myelitis
51. Encephalitis
    a) Post-infectious Measles; Mumps; Pertussis
    b) Von-Economo
    c) St. Louis
    d) Japanese B
52. Lymphocytic Chorio-meningitis
53. Infectious Polyneuritis
54. Meningidites
    Tuberculous
    Meningococcic
    Influenzal, etc.
55. Brain tumor
56. Birth injuries
57. Pre-tibial Fever (Fort Bragg fever)
58. Coxsackie Viral Infections

sudden onset of chills or chilly sensations, severe headache, muscle soreness, and high fever with gradual uneventful recovery. For lack of a better name, the entity was colloquially referred to as a "dengue-like" disorder.

Recently a syndrome simulating poliomyelitis, but caused by a distinctly different virus of the "Coxsackie group" has been reported[9,10]. The true incidence of this disease is not known, since at present diagnosis rests on highly specialized virus study techniques.

Some problems in the diagnosis of poliomyelitis are illustrated by a recent report of Fox and Wallace[11]. These authors observed 87 patients who manifested the clinical and laboratory criteria of poliomyelitis, but not a single patient developed the paralytic form of the disease. It was therefore postulated that this outbreak may have been due to an attenuated or unusal virus strain or that an entirely unrelated type of encephalomyelitis may have been responsible. Whether this may have been related to the Coxsackie or other neurotropic virus infections was not determined.

Young[12] reported four cases of hysterical paralysis seen by him during the 1946 epidemic in Nebraska which should serve to emphasize the importance of anxiety and other emotional factors in suspected cases of poliomyelitis. This report also illustrates the value of determining the precise nature of the paralysis in order to effect appropriate diagnosis and treatment.

That acute appendicitis may be confused with early poliomyelitis has been emphasized by Hobart[13]. The localization of pain, tenderness and muscle spasm are more suggestive of acute

appendicitis. The importance of noting difficulty in swallowing and enunciatoin of syllables or words as early manifestations of bulbar poliomyelitis has been discussed by Toomey[14]. Other factors may of course be responsible for these symptoms, hence laboratory confirmation of the diagnosis is desirable.

Levinson[15, 16] has summarized the clinical history and physical findings in poliomyelitis. A careful evaluation of the history and detailed physical examination provides the background for accurate diagnosis in most instances. Gordon[2] has aptly stated that practical experience indicates the need for better appreciation generally of the clinical nature of early poliomyelitis; the disease is too often first recognized by the presence of paralysis. Equally unfortunate is the tendency during an epidemic to advance the diagnosis of poliomyelitis for many other and more common diseases of childhood without sufficient critical differentiation. This circumstance leads to unsatisfactory management of conditions that are not poliomyelitis, and to undue alarm about the actual prevalence of the specific infection.

## SUMMARY AND CONCLUSIONS

1. Since poliomyelitis simulates many other diseases, the importance of careful and deliberate study of each case tentatively diagnosed poliomyelitis is essential. The hazards of exposing children in whom the diagnosis is unconfirmed emphasizes the necessity for adequate isolation facilities pending the establishment of a definitive diagnosis in any center caring for patients afflicted with poliomyelitis.

2. Although early diagnosis in poliomyelitis is desirable from the viewpoint of both epidemiology and management, errors in diagnosis may unnecessarily jeopardize patients with other diseases of childhood who are not receiving appropriate therapy as a result of mistaken diagnosis.

3. The clinical disorders and symptoms which are most commonly confused with poliomyelitis have been presented.

4. In view of the emphasis on early diagnosis in poliomyelitis, the establishment of a correct presumptive diagnosis in 78.5% of 140 patients reported in this study represents a favorable record of diagnostic accuracy when contrasted with other reports.

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# Poliomyelitis
## A Clinical Pathological Correlation

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Any attempt to correlate the clinical and pathological findings in a disease as complex as poliomyelitis must necessarily be based to a large extent on unproven theories and hypotheses. Little is known about the pathogenesis of the disease and much of our available information concerning the pathologic anatomy has been derived from experimental work with monkeys and from human autopsy studies. Because of the absence of a suitable experimental animal in which to reproduce and study the diseases, we are still pretty much in the dark concerning the mode of entry of the virus, its spread through the body, the factors which determine the sites of its localization, and the mechanism of the body's reaction to the virus. The entire picture is further confused by the fact that the disease is probably caused by several different viruses to which the body may respond in different ways.

The time has come to revise most of our teaching concerning the nature of this disease. Poliomyelitis has always been and is still regarded by most as a disease of the central nervous system which results in paralyses. The paralytic form of poliomyelitis is only one phase of the greatly varied clinical picture which results from infection with the poliomyelitis virus. The disease is basically a generalized virus infection which in a relatively small proportion of cases localizes in the central nervous system and produces paralyses. We know very little about the factors which determine that in one patient the virus shall produce degeneration of the cells of the brain and spinal cord, and in another a very mild and practically insignificant illness, but we do know that infection may be widespread where paralysis is not. The proportion of paralytic to non-paralytic polio may vary tremendously in the same location and in the same year. The incidence of central nervous system involvement may vary from 0 to 80%.

It is quite probable that the virus enters the body by way of the autonomic neurons in the intestinal tract or by the olfactory pathways. This is substantiated by the clinical fact that even though the virus is basically neurotropic, the onset of the disease usually is characterized by either a gastro-intestinal or upper respiratory infection. Further proof of this theory is the observation that the virus can be consistently demonstrated in the feces and in secretions from the nose and throat. In the great proportion of cases the disease does not progress clinically beyond this stage. Whether or not there is involvement of the central nervous system at this stage cannot be established for the obvious reason that these patients do not come to autopsy. However, experimental evidence suggests that changes occur in the central nervous system even though paralysis does not develop.

The rate of spread of the virus from the intestinal tract and upper respiratory tract through the body varies greatly. The progress may be fulminating with the devlopment of paralyses within a few hours, or several days, or as long as a week may elapse before there has been sufficient multiplication and spread of the virus to produce paralysis.

There is also great variation in the localization of the virus once it has spread beyond the barriers imposed by the intestinal and upper respiratory tracts. In addition to involvement of the central nervous system there is also frequently very significant cardiac involvement with demonstrable histologic changes which will be described later.

In the paralytic cases the disease involves the entire central nervous system and is not confined to the anterior and lateral horns as is commonly supposed. In addition to involvement of the central nervous system, there is also considerable evidence of lesions in the autonomic nervous

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system. Clinical evidence to support this contention is provided by the frequent occurrence of urinary retention, rectal incontinence and anhidrosis. This is encountered particularly in those cases with encephalitic manifestations.

In fatal cases, autopsy usually reveals, in addition to degenerative changes in the anterior horn cells, varying degrees of necrosis of the interstitial tissue. This may vary in extent from small focal areas of necrosis to large extensive zones of destruction which may be visible to the naked eye.

The severe pain so frequently encountered in poliomyelitis is produced by this diffuse indiscriminate involvement of the central nervous system. The irregularly distributed character of the necrosis causes both muscle spasm and flaccid paralysis. Paralyzed muscles become overstretched by their spastic antagonists resulting in the severe pain which can usually be overcome by the judicious application of hot packs or the carefully controlled use of curare.

The acute degenerative changes occur as a rule entirely within the first few days. During this period it is extremely difficult to evaluate the amount of neuromuscular involvement. During this period there is considerable reflex inhibition of normal muscles due to the marked pain which the patient experiences on attempting movement of these muscles. This may give the clinical picture of extensive paralysis which actually does not exist. When the spasm and the pain in these normal muscles has been overcome, the true extent of the neuromuscular involvement becomes evident.

The reflex inhibition of normal muscles may also cause marked weakness and incoordination in the early stages of the disease. The muscular incoordination may be further accentuated by involvement of Clarke's column and other cells in the base of the posterior horns.

The most severe changes are encountered in the so-called bulbar cases in which there is involvement of the brain stem. A prominent morphologic feature in these cases is the presence of extensive areas of necrosis in the supporting tissue in addition to degenerative changes in the nerve cells. If death occurs early in the course of the disease many polymorphonuclear leukocytes are found in these areas. If, however, death does not ensue for several days the polymorphonuclear leukocytes are replaced by mononuclear cells.

A prominent feature in the cases encountered in Champaign County last year was the occurrence of encephalitic features, such as extreme irritability, drowsiness, disorientation and muscular twitchings. Very little histologic change is seen to explain these manifestations. Some mononuclear cell infiltration may be found in the cerebral hemispheres, particularly in the region of the precentral gyri, but this is not prominent.

The destruction of the nerve cells may occur very early in the disease, even before any obvious paralysis has become evident. In these early stages there may be destruction of nerve cells without any inflammatory reaction. This explains the not infrequent absence in the early stages of the disease of cellular elements from the spinal fluid. Numerous cases of acute poliomyelitis have been reported in which there was no significant alteration in the cellular content of the spinal fluid. This fact is substantiated by experimental work done on monkeys. After intracerebral inoculation of polio virus into monkeys, a prodromal period ensues which is clinically comparable to the preparalytic phases of the disease as encountered in man. The spinal fluids are consistently normal until the third day before the onset of paralysis. Three days before paralysis occurs only 50% of the animals show any elevation in cell count of the spinal fluid.

This is an important diagnostic consideration and it should be emphasized that a pathological spinal fluid is not necessarily a constant accompaniment of poliomyelitis, particularly in the preparalytic stage of the disease.

The earliest change in the nerve cells is dissolution of the Nissl substance in the cytoplasm. At this stage the process is probably still reversible and the resulting paralysis may disappear if the cell returns to normal. As the process progresses, however, nuclear damage occurs and then the paralyses are permanent.

The early degenerative changes in the nerve cells are followed by an increase in inflammatory cells which is reflected in the spinal fluid. At first these cells are predominantly polymorphonuclear leukocytes but these persist for only a few days and are replaced by mononuclear leukocytes. The latter may persist in the tissues

for several months after the onset of the disease.

The total cell count of the spinal fluid varies greatly. Except for those cases mentioned previously in which the cell count may be normal, the total cell count is usually highest early in the course of the disease and then diminishes until about the third week when it returns to approximately a normal level. The level of the cell count may vary tremendously in paralytic cases and is, as a rule, no index of the severity of the disease, nor is it of any prognostic value. We have observed fulminating bulbar cases with cell counts that ranged between 30-40. In other cases cell counts as high as 2,000 have been reported. Most frequently the cell count ranges between 50 and 250 cells per cubic millimeter.

The variation in the cell count in the absence of any corresponding variation in severity of the disease may possibly be due to different responses induced by the various strains of the virus. This may also account for variations observed in the differential cell count. It is an established fact that different strains of the same virus or closely related viruses may elicit cellular responses which vary in quality as well as in quantity.

Coincident with the alteration in cellular content of the spinal fluid, there is also usually an elevation in total protein content. Normal range for spinal fluid protein is usually given as 20 to 25 milligrams per 100 cc. of spinal fluid. In the early stages of the disease the protein level is normal or slightly elevated. The protein content usually reaches its peak about the fourth week of the disease and may remain elevated for as long as 10 weeks after the onset of the illness. The average protein level in large series of cases usually runs about 40 to 60 milligrams per 100 cc., but cases have been reported in which it has reached a value of 300 milligrams percent in the later stages of the disease.

The effect of poliomyelitis on the heart deserves very careful consideration. In planning therapy all efforts are usually directed at preventing and overcoming the effects of the virus on the neuromuscular system. Very little or no attention is paid to the patient's cardiac status despite the fact that careful clinical evaluation in fatal cases usually reveals definite evidence of cardiac decompensation. Recent studies by Saphir and others indicate that severe inflammatory changes may occur in the heart muscle in fatal cases of poliomyelitis. This is characterized by the presence of foci of lymphocytic infiltration. The myocardium is soft and flabby and presents the typical gross and microscopic appearance seen in acute myocarditis.

At autopsy these patients show definite evidence of decompensation. In addition to the gross and histologic evidence of myocarditis, passive hyperemia of liver, lungs and kidneys is frequently observed. The severe edema of the lungs which is almost constantly present in fatal cases is probably due to cardiac decompensation resulting from the myocarditis.

Histologically, the type of myocarditis observed cannot be distinguished from the myocarditis observed in other infectious diseases. Because of this, doubt has been cast on the role of the poliomyelitis virus in the production of this myocarditis. It is possible that this lesion may be due to secondary bacterial invasion. Nevertheless, the incidence of myocarditis is too high to be ignored and it should be given careful consideration in establishing therapy.

Lesions in skeletal muscle are also frequently found in poliomyelitis. Foci of lymphocytic infiltration may be found scattered throughout the muscle presenting the typical picture of a myositis. This is usually not extensive but occurs too frequently to be ignored. The role of this lesion in the production of muscle spasm and pain cannot be ignored.

# Penicillin in the Treatment of Congenital Syphilis

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The use of penicillin in the treatment of congenital syphilis has been an advance over the old style of treatment. The most striking results have been obtained in the early congenital cases or infantile syphilis. As might be expected, the results are less brilliant, in fact disappointing, in the treatment of late congenital syphilis or in children three years or older.

This report deals with 36 infants and children treated with penicillin G or with procaine penicillin from 1945 to the present. These patients are from the two Children's Syphilis Clinics under my direction at the University of Illinois' Research and Educational Clinic, and at the Central Free Dispensary of Presbyterian Hospital, Chicago. In order to evaluate the use of soluble penicillin and of procaine or slow penicillin, the results are given for each type of therapy. Also, because there is a marked difference in results in the age groups, infants and older children, the results in these groups are set forth.

The patients were divided as follows:

| Penicillin G | |
|---|---|
| Presb. Hosp., C.F.D. | U. of Ill., R. & E. |
| 9 cases (1 white, 1 Mexican, 7 Negro | 10 cases (1 white, 9 Negro |
| **Procaine Penicillin** | |
| 14 cases (1 white, 1 Mexican, 12 Negro | 7 cases (7 Negro |
| (2 cases retreated after penicillin G) (both Negro) | (2 cases retreated after penicillin G) (both Negro) |

There were a total of 40 separate series of penicillin treatments in the 36 children.

*Penicillin G Treatment In Infantile Syphilis.*—Of the 19 children treated with penicillin G, 7 were 2 years or under. In these cases of infantile syphilis 6 were acutely involved with skin lesions or bone lesions or both. It is not uncommon to have mortality in this group. We were fortunate to have no fatalities in this group or in any of the children treated with penicillin in either clinic.

The dosages of penicillin G in infants varied from 95,000 units / Kg. to 164,000 u/Kg in the 3 cases at Presb. Hosp. clinic, and from 118,000 u/Kg. to 1,311,000 u/Kg. in the 4 infants at the University of Illinois clinic. The only relapse was in a 20 month old child who received 95,000 u/Kg., was seronegative at 8 months but seropositive at 12 months after treatment. She was retreated with penicillin G 164,000 u/Kg. (14 months after the original treatment). She was negative in 4 months, positive at 7 months and seronegative from the 8-25th months after re-treatment. Two infants, although now clinically and serologically negative, were treated recently and have been followed only 3 and 5 months respectively. The dosages, 1 @ 1,310,000 u/Kg. and 1 @ 231,000 u/Kg. were sufficiently high to expect continued good results. The other four infants responded satisfactorily to treatment with persistently negative Wassermann and Kahn blood tests.

| | | | | | | |
|---|---|---|---|---|---|---|
| 2½ | mos. | 154,000 | u/Kg. | Neg. | serologies | 11-39 mos. after treatment. |
| 15 | mos. | 107,000 | " | " | " | 12-30 mos. after treatment. |
| 2 | wks. | 1,100,000 | " | " | " | 3-12 mos. after treatment. |
| 2 | yr. | 118,000 | " | " | " | 3-11 mos. after treatment. |

In the above infants the first two had negative Wassermanns at 4 months each after treatment but had positive Kahns until the eleventh and twelfth months respectively after treatment. To summarize for the infants with early congenital syphilis treated with penicillin G, 5 of the 7 seem cured (one had to be retreated) and the

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other two treated recently with large doses are seronegative and probably cured.

*Penicillin G in Late Congenital Syphilis.*—The dosages of penicillin G in 12 older children varied from 37,000 u/Kg. to 100.000 u/Kg. in the six children at Presbyterian Hospital clinic, and from 64,000 u/Kg. to 207,000 u/Kg. in the six children at the University of Illinois clinic. Two patients from each clinic were retreated with penicillin in oil followed by 15-20 weekly injections of bismuth subsalicylate. These four children were treated originally with dosages of 37,000 u/Kg. to 75,000 u/Kg. and had been followed 11 to 17 months after first treatment so that their continued positive serologies indicated failures to cure. (Three continue to be positive after retreatment 3 to 11 months now and one is doubtful 10 months now). Two of the 12 children are considered cured. One has been negative from the 6th-18th months after treatment. The other child has had negative serologies from the first through the 21st months after treatment. This child, a younger sister of a resistant case, had a negative Kahn on admission to the clinic but had a positive Wassermann and a doubtful Kahn after a provocative, and was therefore treated. However, she was considered to have had her infection fairly well under control by virtue of her own defense mechanism. She had not been treated previously.

Five out of the 12 older children treated by penicillin G have had fluctuating negative and positive serologies for 18, 20, 14, 5, and 18 months respectively after treatment and are considered doubtful. The patient counted as doubtful after 5 months followup was lost to this clinic because of committment to Manteno State Hospital in June 1948 because of a psychosis. His spinal was negative before treatment was started. His Wassermann was negative and also the Kahn when last seen in the clinic.

The remaining 5 out of the 12 children were considered unsatisfactory in their response to treatment with penicillin G. They had positive serologies 19, 17, 11, 17 and 13 months respectively after treatment. Four of these have been retreated with penicillin in oil as stated above and the fifth child is awaiting retreatment. (or further treatment)

Thus the results of penicillin G therapy in the 12 older children were very unsatisfactory so far as an early cure is concerned. It is true that the dosages were not as high proportionately as in the infantile group, e.g. 37,000 u/Kg. for one patient, 1 @ 64,000, 2 @ 67,000, 3 @ 75,000, 1 @ 95,000, 2 @ 100,000, 1 @ 112,000 and 1 @ 207,000 u/Kg. The two who were considered cured were treated at 60,000 and at 75,000 u/Kg. and yet those who were considered unsatisfactory received around 2,000,000 units per child. (37,000 to 207,000 u/Kg.)

Summary of results

Penicillin G in Infantile Syphilis
- 7 cases (2 wks. to 32 mos.) (6 florid cases)
  95,000 to 1,311,000 u/Kg.
- 5 cures and 2 probable cures

Penicillin G in Late Congenital Syphilis
- 12 cases (3 yrs. to 13 yrs.)
  37,000 to 112,000 u/Kg. (average = 75,000 u/Kg)
- 2 cures
- 5 doubtful
- 5 unsatisfactory

Procaine Penicillin in Late Congenital Syphilis
(No infantile cases treated with procaine pen.)
- 21 cases (5 yrs. to 15 yrs.)
  100,000 to 200,000 u/Kg. (15 received 100,000 u/Kg.)
- 2 cures
- 12 doubtful
- 7 unsatisfactory

*Procaine Penicillin Treatment.*—When penicillin in oil became available we decided to use this type of medication by daily injection to outpatients in the clinics. All patients receiving pencillin G had been hospitalized for such number of days necessary, usually 7 to 14 days. The new method saved hospitalization costs and spared beds for other patients. No infants have been treated with penicillin in oil. Twenty-one children 5-15 years old with late congenital syphilis were treated with penicillin in oil or some form of procaine penicillin. There were no reactions or sore hips encountered. Four of the 21 children were relapsed patients who had been treated with penicillin G 12-19 months previously and were still positive. (Three still positive; one doubtful now). They also received 15-20 weekly bismuth injections.

Seven of the 21 are considered unsatisfactory with positive serologies 12, 8, 12, 8, 6 and 10

months after treatment. One of these children has moved to another city.

Twelve out of the 21 are considered doubtful in their response to penicillin in oil, with fluctuating negative and positive serologies 14, 12, 11, 9, 5, 3, 6, 9, 10, 8, 8 and 12 months respectively after treatment. Eight of these 12 have had 15-20 weeks of bismuth after the procaine penicillin. Several of these patients undoubtedly will turn negative under further observation.

Two out of the 21 are satisfactory 10 months each after procaine penicillin. One of these may have been an acquired case and one was a weakly positive younger brother of a congenital neurosyphilis patient. These two probably represent cases which are easier to cure than the others in the group of late congenitals.

Even so the results with daily injections of procaine penicillin at 100,000 or slightly more units per Kg. are no worse and probably better than with the three hourly injections of the soluble penicillin G. The fact remains that even with bismuth following procaine penicillin or soluble penicillin we are *not* curing any appreciable number of the cases of *late* congenital syphilis. The use of penicillin still represents an improvement over the old style treatment of arsenic and bismuth in that one can probably do as much good in late congenital syphilis with 10 to 21 days of procaine penicillin and 15-20 weeks of bismuth as he could with 1 or 2 years treatment with arsenic and bismuth. Penicillin in large doses 100,000 to 400,000 u/Kg. is quite satisfactory in infantile or early congenital syphilis even without bismuth afterwards.

Since penicillin is tolerated very well in children as judged by the absence of reactions, Herxheimer or sensitivity, in our entire group of 36 patients, it may be wise to treat older children with dosages up to 400,000 u/Kg. Because of the huge total doses involved for the larger children we have not done this so far. Moreover, the effect of aureomycin in congenital syphilis should be determined. It works well in early acquired cases, according to some preliminary reports.

(The work at the Presbyterian clinic was aided by a grant from the Goodspeed Fund; the Upjohn Co. furnished penicillin in oil for 5 patients and the Abbott Laboratories furnished crystalline procaine penicillin used in two patients treated at the University of Illinois Clinics.)

## DISCUSSION

Dr. Eugene T. McEnery: The question of syphilis has always been of interest. It is rather interesting to think back to the number of syphilitic cases that we were privileged to see, say, maybe fifteen or twenty years ago, especially at County Hospital. It was a very common thing to see infants who had syphilis. But now — I think Dr. Shaw will bear me out — the demonstration of a baby with syphilitic lesions, as a newborn, is sort of an unheard of thing. I haven't seen one for years. It is very difficult to demonstrate these cases to students. The situation of syphilis has changed. In the Clinic at Children's Hospital where about fifteen years ago we had a very large Clinic there once a week and would see anywhere from twenty-five to thirty-five patients there for treatment, at the present time that has dropped down to, I'd say, maybe five or ten patients a week.

The question that I'd like to ask Dr. Shaw is: Do you think that the incidence of syphilis is increasing within the past five years? They always say after war years you are bound to get more syphilitic patients. My experience with new-born babies certainly hasn't demonstrated that. I haven't seen any syphilis in any newborn baby for practically ten years. Maybe we miss them because they have a different type of syphilis because if the mother is treated early, you don't get congenital syphilis. The situation certainly has changed in the Clinics I have had the privilege of attending.

## DISCUSSION

Dr. Noel G. Shaw: "During and after a war there is an increased incidence of venereal disease. However, with the rapid treatment of acquired syphilis there is not the great spread of syphilis that occurred in the First World War.

The routine premarital tests and the serologies taken at work have helped in case finding so that syphilis can be treated and its spread minimized. The greatest aid in reducing the number of cases of congenital syphilis is the routine serologic tests in the pregnant mother and giving her enough treatment to prevent the disease from appearing in the newborn. It is true we are seeing some few cases of active syphilis in infants and newborns, but not many. Adequate treatment in the mother (18-20 injections of heavy metals in the last one-half of pregnancy, or a course of penicillin 600,000 u. daily for 10 days) will prevent congenital syphilis in at least 90% of the cases. We can and should wipe out congenital syphilis."

# Protruding Ears: Correction by Plastic Surgery

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Malformations of the auricle are not unusual and may range in severity from complete absence to macrotia. By far the most common deformity is the protruding ear.

Since little importance can be ascribed to the function of the auricle, it is only because of the deleterious psychic effect on the patient that protruding ears assume a clinical significance. Actually, according to the comparative anatomists, the external ear in man is undergoing regression. In comparing the auricular muscles in man to those of animals with similar type ears, a definite diminution to atrophy is evident. In lower animals the auricle has real function for determining direction of sound and for protection of the internal auditory mechanism. Some animals, on stimulation of the tragus will close the ear canal by an infolding of the auricle to serve as a protection from water or insects.

The psychic effects of protruding ears vary with the sensitivity of the individual. In almost all my cases, and surprisingly enough it was marked in children, a feeling of insecurity was evident in these patients, since this deformity unlike most deformities produces reactions of mirth in other people. Being constantly reminded and ridiculed about a deformity will break all defense mechanisms of repression which the patient might have developed, and subjects the individual to an insecurity or inadequacy neurosis. It is fortunate for these individuals that this deformity can be corrected simply and satisfactorily, preferably at an early pre-school age before any real psychic trauma can be inflicted. Other patients who are not at all sensitive about their appearance or defects may desire a correction of the ears purely from an economic or social standpoint.

The normal ear is a thin, shell like structure, having definite depressions and projections. Many variations are found which may still be considered within normal limits. It is only when the ear protrudes abnormally or is absent that the defect is immediately noticeable. Very large or very small ears which may be proportionately more deformed than a protruding ear may go unnoticed if they are placed in a normal relationship to the head.

The cartilage of the auricle consists of a single piece, which gives form to the ear and outlines the landmarks. It is absent from the lobule and is deficient between the tragus and the beginning of the helix. At the front part of the auricle, where the helix bends upward, is a small projection of cartilage, called the spina helicis. At the lower part of the helix the cartilage is prolonged downward as a tail-like process, the cauda helicis, which is separated from the anthelix by a fissure, the fissura antitrago-helicina. The cranial aspect of the cartilage exhibits a transverse furrow, the sulcus anthelicis transversus, which corresponds to the inferior crus of the anthelix and separates the eminentia conchae from the eminentia triangularis. Another furrow exists at the central region of the concha, known as the sulcus cruris helicis, which corresponds to the continuation of the helical rim and separates the concha into two portions, the cavum concha and the cymba concha.

In examining the normal ear from behind, it will be noted that the concha forms a 90 degree angle with the head. The scapha likewise forms an angle of approximately 90 degrees with the concha, but this may vary as much as 10 to 15 degrees and still be within normal limits according to Young[1]. The rim of the helix is then noted to turn outward slightly. The angle between scapha and concha is formed by the anthelix and in the absence or underdevelopment of the anthelix the angle may become obtuse, thereby resulting in a protrusion of the auricle away from the head. Since the angle of the anthelix more or less determines the degree of ear protrusion, the pathology would resolve itself to the type and development of the anthe-

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lix, i.e., the more obtuse the angle, the more the ear projects. The measurement of the angle formed by the head and the helix is known as the auriclo-mastoid angle and is usually about 30 degrees.

The earliest reference to the correction of protruding ears was made in 1845 by Dieffenbach, who advised the removal of skin from the back of the ear, followed by the suturing of the ear cartilage to the mastoid periosteum. Ely[2] in 1881, Keen[3] in 1890, Monks[4] in 1891, Joseph[5] in 1896, and Morestin[6] in 1903 advised removal of large sections of skin from the auriculo-mastoid angle along with the excision of a section of conchal cartilage which lies adjacent to the mastoid process. These methods are not advisable.

The basic concept for the newer type of otoplasty was first described by Luckett[7], who, in 1910, pointed out that the reason for protruding ears was the absence or underdevelopment of the anthelix. If a new anthelix were made, the prominence of the ear could be overcome and furthermore on a lateral view a more normal appearing ear resulted without the distortions of the concha and absence of the normal anthelix fold. Luckett's operation consisted of the removal of a crescentic area of cartilage and skin from the posterior surface of the auricle over the line of the proposed anthelix, the cartilage edges are everted by the use of a Lembert type suture, thereby, forming a new anthelix.

Davis, in conjunction with Kitlowski in 1937[8] published a method they had been using for correcting protruding ears, based on the concepts of Luckett. They outlined the new anthelix along the inferior crus with brilliant green perforated through the skin with a needle from the anterior surface of the auricle. The skin on the posterior surface of the auricle which is removed both from the conchal and mastoid regions is discarded. The cartilage is split along the previously marked line and a section removed. They emphasized that the cartilage must be split through the entire length of the proposed anthelix to break its spring. Catgut sutures close the perichondrium and evert the edges to form the new anthelix.

The objection to the Davis-Kitlowski procedure is that the normal post-auricular sulcus is obliterated by the excess removal of skin from the posterior surface of the auricle and from the mastoid region. Also in the removal of cartilage only from the inferior crus, the superior crus may appear flat and at times the ear will appear to lop forward at its upper pole.

The Davis-Kitlowski procedure led to a modification by New and Erich[9] in 1940 who used mattress sutures externally to help hold the form of the new anthelix. They also used the excision of cartilage from the inferior crus but at times felt it necessary to remove a wedge of cartilage from the superior (posterior) crus to prevent the upper pole of the ear from falling forward.

Young,[1] in 1944, described a similar, but improved method, to the Davis-Kitlowski procedure, but also excised a long strip of cartilage.

These procedures in which a large strip of cartilage is removed will leave a sharp "unnatural" ridge on the surface of the auricle (see Figure 1).

Pierce, Klabunde and Bergeron[10] correct protruding ears by eight to ten incisions almost through the cartilage, to avoid a sharp ridge. However, in my experience this procedure will not suffice in properly correcting most ears and is applicable only in slight protrusions.

The fact that so many procedures have been described for the correction of protruding ears, leaves the impression that no one ideal method has been found. At times it is necessary in certain types of ears to use a variety of methods since no one procedure will suffice for all. However, the method to be described,[11] with the variations which are outlined for different types of protrusions, quite accurately reproduces the normal with almost uniform success. (Figures 2, 3, 4 and 5).

*Operative Technique.*—Local or general anesthesia is used depending on the age of the patient.

An incision through the skin and perichondrium is made on the posterior surface of the auricle in the region of the margin between scapha and concha, i.e., in the fossa anthelicis, and extends at the superior portion to the junction of the ear and the temporal region while at the inferior portion it extends down to the base of the antitragus close to the mastoid region. The skin and perichondrium are then undermined laterally almost to the auriculomastoid angle and to the beginning rim of the

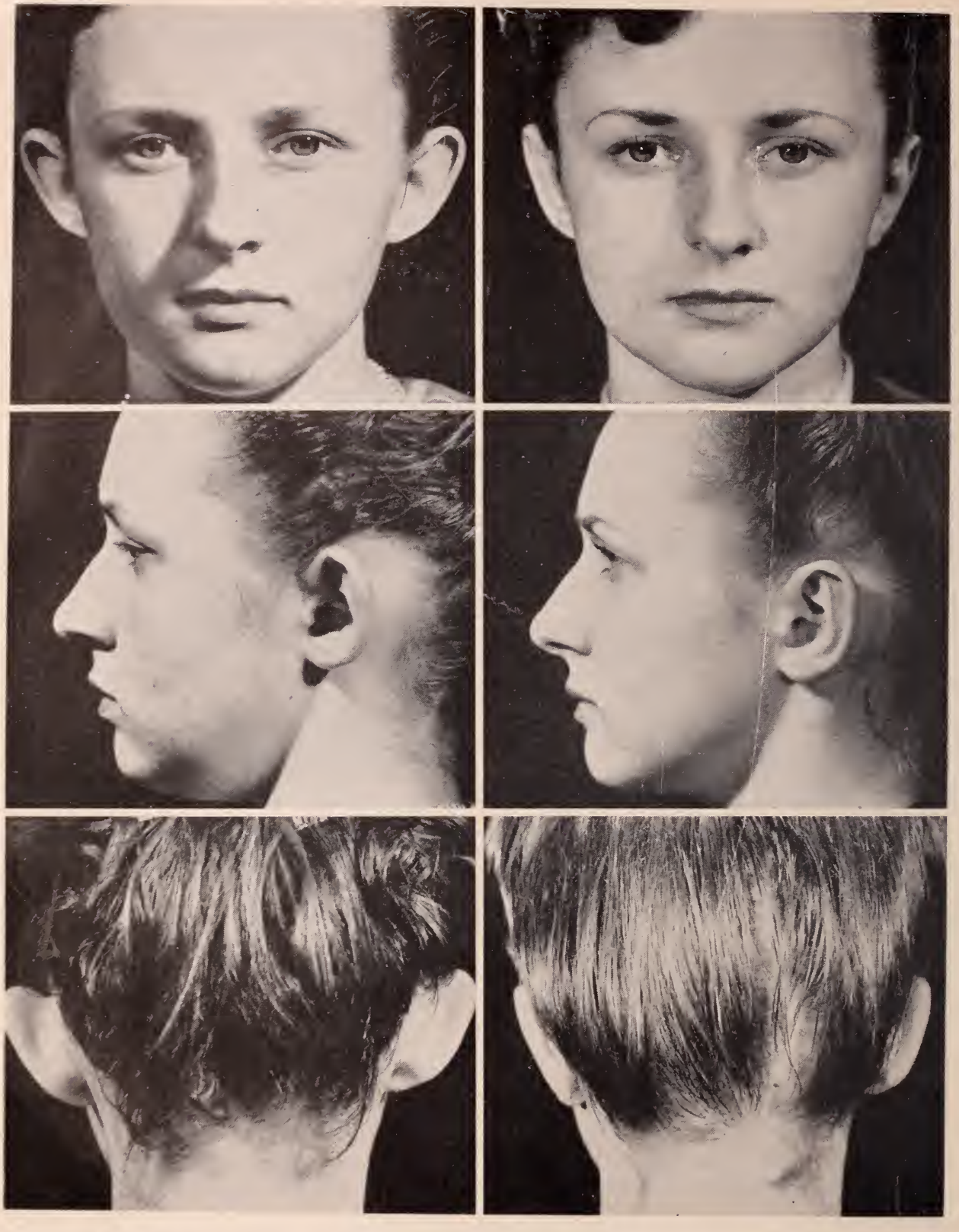


Figure 1. Protruding ears corrected by the usual or standard method of cartilage excision. Note that the corrected ears are placed back to the head, but in the lateral view a sharp ridge is present in the region of the superior crus. This results in an ear that is unnatural in appearance.

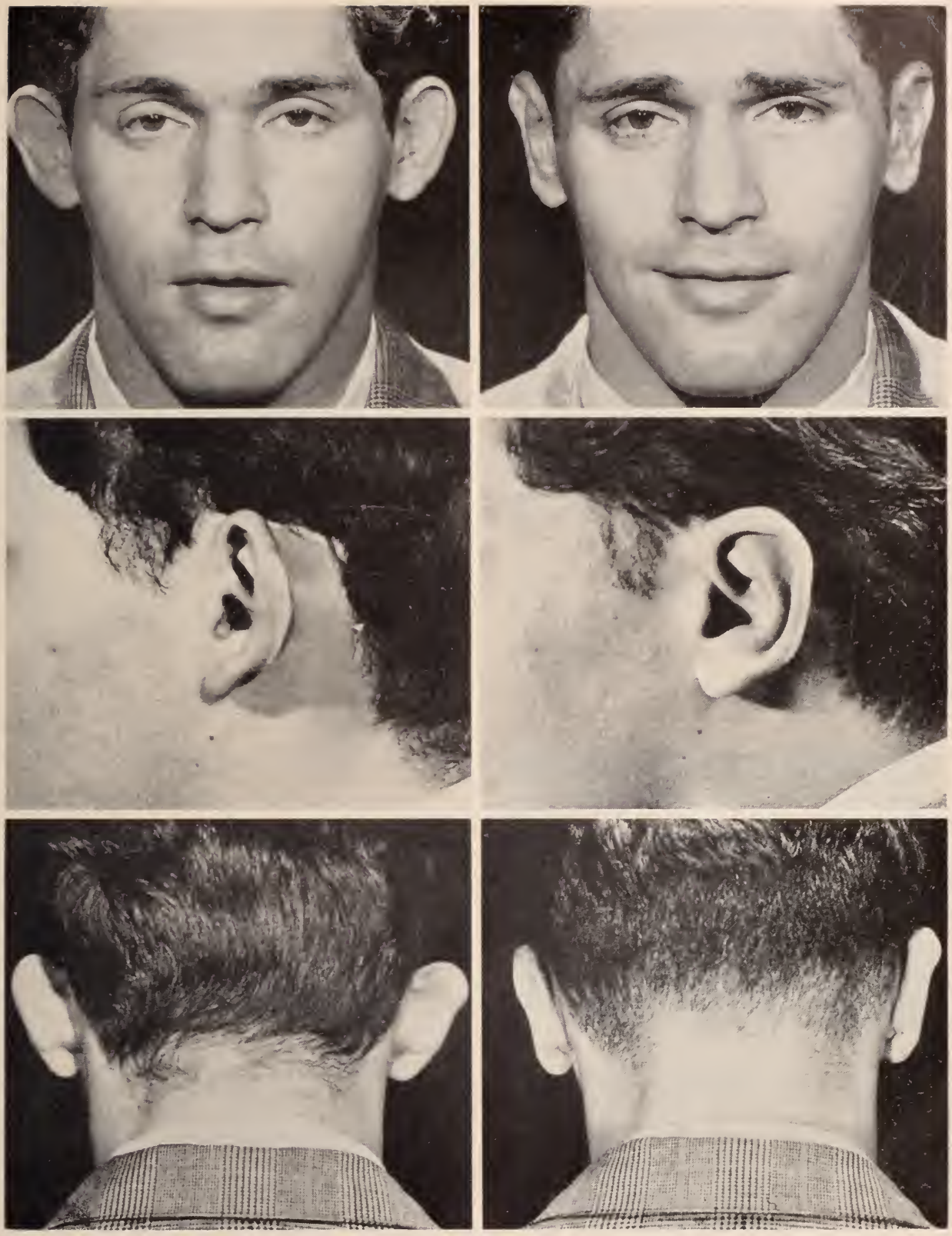


Figure 2. Correction of bilateral protrusion of the ears by the author's method. The angle of the anthelix is obtuse, which accounts for the protrusion of the ear. The normal anthelix angle is from 80 to 100 degrees. The formation of a normal anthelix by the method described, and very little sacrifice of skin from the posterior region of the auricle forms an ear which satisfactorily simulates the normal.

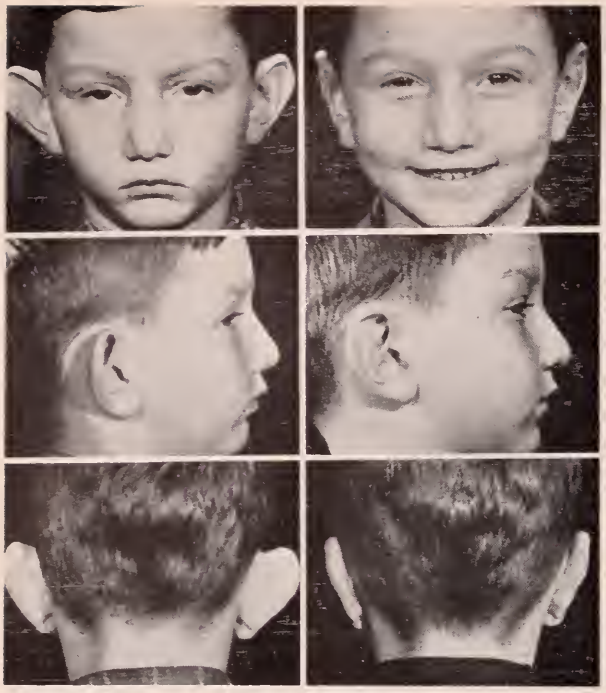


**Figure 3. Marked protrusion and cupping of the ears corrected by the method described. In the pre-operative photographs it is noted that there is a complete absence of the anthelix and its superior crus. The inferior crus is present but not well defined. Post-operative photographs reveal normal appearing ears in all views.**



**Figure 4. Protruding ears corrected by the method described. Note that the corrected ears present a normal contour of the anthelix and superior crus on the lateral view. (A nasal plastic operation was performed at the same time that the ears were corrected).**



**Figure 5. Unilateral protrusion of the ear with associated mandibular deformity. Correction of ear by the method described and correction of face deformity by a thoracico-epigastric pedicle skin graft and iliac bone graft to mandible.**

helix, thereby exposing the whole posterior surface of the ear cartilage and all its landmarks.

By folding the ear back against the head, the new anthelix is noted on the anterior surface of the auricle. The skin and cartilage are then punctured through from the anterior surface with a fine needle and each point marked on the posterior surface of the ear cartilage with methylene blue to outline the cartilage incision. The double row of marks resulting from this maneuver, are so placed that they completely delineate the posterior and anterior borders of the anthelix and its superior crus. At the upper end, the markings converge to a curved apex in the region of the superior crus of the anthelix as it merges with the helix. The inferior border comes to a point at the fissura antitragohelicina.

Two incisions are made through the cartilage, one along each of the markings. A section of cartilage is then removed from the anthelix. This excision starts at the fissure antitragohelicina, and continues to an apex opposite the sulcus antihelicus transversus so that a diamond

shaped piece of cartilage is removed. The size of the cartilage excision depends on the amount of spring which must be overcome. The skin is then undermined laterally for a few millimeters on the anterior surface of the auricle. No cartilage is removed from the superior crus.

The cauda helicus which has already been exposed is then completely removed unless the deformity is completely confined to the upper portion of the ear, in which case it may not be necessary. However, in my experience it has been necessary in almost all cases to remove the cauda helicus, for in most cases there is a prominence and a cupping of the lower portion of the ear with a projection upward of the ear lobe. Since removal of the cauda helicus does not cause any distortion of the auricle on the anterior surface, it has proven advantageous in most cases to remove it.

A small transverse section of cartilage is now removed from the upper end of the superior crus, at its junction with the helix. This is necessary to completely break the spring of the anthelix and superior crus from its attachment to the cartilage of the helix. If this section of cartilage is removed close to the helix, no visable fold or defect will be seen on the anterior surface of the superior crus, since it is hidden under the rim of the helix.

In cases where there is severe cupping and projection of the ear lobe and lower portion of the ear which excision of the cauda helicus had not completely corrected, a strip of cartilage is removed from the concha, adjacent to the cauda helicus.

Three or four catgut (mattress type) sutures are inserted through the perichondrium along the margins of the original cartilage incisions and tied just tightly enough to form the new anthelix fold. In many cases, external mattress sutures tied over cotton rolls, as suggested by New and Erich were used instead of the internal catgut fixation sutures. The external mattress sutures proved to have a definite advantage over the internal catgut fixation sutures in forming of the anthelix and superior crus. In most cases the cartilage is soft and pliable, so that no internal or external fixation sutures are necessary.

A section of the excess skin is removed from the posterior surface of the auricle and the skin margins closed with interrupted fine black silk. Sterile wet cotton or rubber sponges are placed in the convolutions of the ear on the anterior surface and a fairly snug pressure bandage applied. The bandage is left untouched for five days at which time the ears are inspected and rebandaged, and if external mattress sutures were used, they are removed at this time. On the seventh day the skin sutures are removed and a light mastoid type bandage reapplied for four or five days.

## CONCLUSION

An original method of reconstructing protruding ears, which has yielded highly satisfactory results in the simulation of normal ears, is presented. By this procedure the ear is placed in its proper position to the head, does not obliterate the post auricular sulcus and leaves a smooth superior crus of the anthelix. The lower pole of the ear is corrected by the removal of the cauda helicus.

Since a protruding ear causes no disability, its clinical significance lies in the deleterious psychic effect on the patient, especially in children, who are frequently ridiculed for this abnormality. For that reason the operation should be done in children, especially in the pre-school ages. Adults who may not be sensitive about their appearance may desire a correction of their ears purely from an economic or social standpoint.

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# Sections vs. Smears in the Study of Bone Marrow

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*Dr. Block*: Although needle aspirates of bone marrow may be examined in smears and sections, only smears have found wide acceptance in clinical hematology. Several years ago a comparison of smears and sections obtained from the marrow of a patient with Gaucher's disease made me aware of the deficiencies of the smear technique. Since that time, approximately 1500 marrow aspirates, most of which were obtained with a modified 8 gauge needle, have been studied in both smear and section. An attempt will be made on the basis of this comparative study to point out certain errors which are commonly made in interpretation of marrow smears as well as errors inherent in the smear technique.

One of the objections to the use of sections has been the alleged inability of even experienced hematologists to recognize marrow cells in section. This is a valid objection in marrow sections prepared by routine methods. However, utilization of the Maximow technique (Zenker formal fixation, celloidin sections of 6 micra and hematoylin-eosin-azure II staining) will result in sections in which the trained microscopist will be able to differentiate the various cells at least as easily as in smears.

Review of the histology of the marrow explains some of the errors inherent in the smear technique. The marrow framework is made up of reticulum fibers and reticulum cells. Venous sinusoids, arterial capillaries as well as larger vessels are supported by reticular fibers in this framework. The hematopoietic cells, depending on the individual cell type, are dispersed singly or in groups, and are found in varying degrees of fixation by the reticular fibers. Consequently when aspiration and then smear is performed, the frequency with which a given cell is found in smear is a function of its location in the marrow, particularly the degree to which it is hemmed in by other marrow cells and the degree to which it is bound by reticulum fibers, as well as a function of the number of that cell in the marrow.

Reticulum cells, which are most completely invested by reticulum fibers, are found much less frequently in smears than in sections, while the cells circulating in the sinusoids are found in higher percentage than they actually exist in the marrow. In some marrow smears the only cells seen are those derived from the circulating blood, giving a completely false impression of the constitution and cellularity of the marrow.

Plasma cells are located inside the reticular fiber framework of arterial capillaries and consequently are rarely seen in smears except in multiple myeloma. If this network is ruptured the plasma cells may be found in groups of 2 to 5 cells in isolated areas in the smear and given undue weight or missed entirely in a count based on random enumeration of a marrow smear.

The presence or absence of megakaryocytes has great diagnostic significance in the differential diagnosis of the various types of thrombopenias. Study of sections will demonstrate the presence of megakaryocytes when none have been seen in the corresponding smears, thus validating the diagnosis of primary thrombopenic purpura.

Conversely, where megakaryocytes are absent or extremely rare in sections one may be sure that a similar situation exists in the marrow. Marrow sections rather than smears are more reliable preparations upon which to base the statement that megakaryocytes are indeed absent or greatly reduced.

The absolute cellularity or degree of fibrosis of the marrow may be difficult if not impossible to estimate from the smear. An acellular smear may be obtained from hypercellular, normocellular or hypocellular marrows. Some of the most densely cellular marrows, as in carcinomatosis, leukemia, or polycythemia, may constantly yield acellular smears. If two successive attempts at aspirating marrow have failed to yield a satisfactory smear or section, a surgical biopsy should be performed, since in 85% of such cases an abnormal marrow will be found.

Granulomas of various nature are always found more frequently in section than in smear since the granulomas are broken up by the smearing process. Other lesions which may exist in nodular form as multiple myeloma, metastatic carcinoma, or lymphosarcoma are discovered in higher frequency in section than in smear. Conversely, one may rarely smear out a normal lymphatic nodule resulting in an abnormally high percentage of lymphocytes leading to a diagnosis of a lymphoma, whereas a study of sections will reveal a normal marrow.

In certain diseases, study of the marrow architecture, as well as marrow cytology, may reveal a pathognomonic histopathology when corresponding smears fail to yield diagnostic information. For example one may differentiate with greater accuracy pernicious anemia from other megaloblastic and erythroblastic hyperplasias, chronic myelogenous leukemia from leukemoid reactions and from the regenerative, hyperplastic stage of an acute toxic neutropenia, and primary from secondary polycythemia. In section, primary polycythemia untreated by irradiation or cytotoxic drugs has an appearance which is practically pathognomonic. Diseases of reticulum cells as the fat storage diseases are diagnosed with greater accuracy by study of sections than of smears since the reticulum cells are so rarely seen on smear.

One of the most frequent errors in the interpretation of smears has been that of making a diagnosis of leukemia on the basis of an acellular smear. Although an acellular smear may be obtained from patients with leukemia, all leukemic marrows except about 4% of cases of chronic myelogenous leukemia, have densely cellular marrows. In the past 2 years I have not infrequently encountered cases of acute neutropenia, hypersplenism, metastatic carcinoma, myelofibrosis with myeloid metaplasia and primary refractory anemia diagnosed incorrectly as acute or chronic leukemia because of the finding of an acellular smear with an elevation of the percentage of stem cells. Examination of sections of the marrow in these cases would have almost certainly avoided this error.

The percentage distribution of cells as well as the total cellularity of the marrow cannot be determined except to a very rough qualitative degree in smear. Consequently in an attempt to trace the effect of therapy upon marrow by the study of smears alone one is faced with the fact that variations in the technique itself are usually as great as those resulting from therapy. Sections are absolutely irreplaceable in this regard.

I have tried to explain and enumerate some of the diagnostic errors encountered in the examination of smears of marrow aspirates as well as to list the situations in which examination of sections could be of service. In spite of the numerous pitfalls awaiting the unwary or the overenthusiastic in the examination of these smears, I would like to emphasize that their study has a definite place in clinical medicine today. I hope that this presentation of the errors inherent in the technique of examination of marrows will increase the accuracy of deductions based upon examination of smears of marrow aspirates.

*Dr. Louis R. Limarzi, Associate Professor of Medicine*: Sections have a definite place in the study of bone marrow. They are useful in certain research projects and are sometimes helpful in the diagnosis of metastatic carcinoma, aplastic anemia, myelofibrosis or myelosclerosis, and certain granulomas involving the bone marrow. Nevertheless, smears are fully as important as sections and the latter method should always be correlated with the former in establishing a diagnosis. There is no "all inclusive" method of studying bone marrow. Furthermore, errors are inherent in all methods used. If we consider

the overall indications for sternal marrow study, only a small percentage of cases require examination of sections while in the vast majority smears are entirely adequate for diagnosis, superior in cytologic detail and more economical of time and money. At least 48 hours are required for the preparation of sections whereas only minutes are necessary with smears. With a busy hematologic service the economy of the smear method is soon evident. Any comparative study of the two techniques must be evaluated according to the method of preparing marrow smears. Many workers doing occasional or even frequent marrow studies have not learned how to prepare acceptable smears. Proper technique of aspiration, smearing, and staining is mandatory for optimal interpretation. Unfortunately, Dr. Block has not shown us any of his smear preparations for comparison with the sectioned material.

In the acute leukemias cellularity of the marrow is of no diagnostic importance. Morphologic identification of leukemia cells is the important point. In the chronic leukemias cellularity is important and can usually be ascertained with proper aspiration technique. We determine this by the percentage of packed nucleated cells in a centrifuged heparinized aspirate.

I would question the statement that there is a characteristic bone marrow picture in polycythemia. Marrow study provides confirmatory but not diagnostic evidence of this disease.

Myeloma cells, Gaucher's cells, metastatic tumor cells and other specific cells seen in Niemann-Pick's disease, neuroblastoma, histoplasmosis, kala-azar and megaloblastic erythropoiesis are found on film preparations; and the additional architectural arrangement of these cells as observed in histologic material adds nothing to the diagnosis. We have found smears to be sufficiently accurate in the evaluation of megakaryocytes for all routine purposes. Our experience in the study of over 5,000 bone marrow preparations has emphasized the fact that the exclusive use of sectioned material often leads to error in the morphologic identification of specific types of cells. This has been confirmed by most morphologists and hematologists; even after the use of special staining techniques. The error in the identification of the several types of myeloma cells as described in the literature is due to the exclusive use of sectioned material. The "L.E." cell seen in bone marrows smears (heparinized bone marrow) from cases of acute disseminated lupus erythematosus will be missed if Doctor Block's method of studying bone marrow is used exclusively.

Finally, a word as to the proper use of bone marrow examination. This procedure is an adjunct to diagnosis and as seen may alone lead to the proper evaluation of the prognosis and diagnosis. However, sternal marrow examination should not be done before all the possible information has been obtained from the history, physical examination and complete study of the peripheral blood picture. Then, if a diagnosis is not available, a sternal puncture is indicated. Even then, in inexperienced hands, a dry tap or an improper aspiration may lead to an incorrect diagnosis.

*Dr. Block*: I will agree that most hematologic conditions may be diagnosed by the marrow smear, but I maintain that certain entities will be missed unless sections are examined. In the case of polycythemia vera no other condition resembles the appearance of the sectioned marrow. We have fifteen to twenty cases in which we feel that we can make the diagnosis merely by examining the bone marrow section. I would question the statement that cellular morphology is diagnostic of acute leukemia. At the International Congress of Hematology at Buffalo in 1948 there was an exhibit of approximately 12 cases of metastatic carcinoma incorrectly diagnosed as acute leukemia on the basis of smears of sternal marrow by experienced hematologists at the University of Michigan.

*Dr. Harry A. Waisman, Research Associate in Pediatrics*: In some of our acute leukemias we have performed marrow aspirations on fifty or more occasions. Is it possible that we might induce a local fibrous reaction as a result of these repeated punctures?

*Dr. Block*: We have never seen such a reaction.

*Dr. Waisman*: We have also seen cases clinically diagnosed as leukemias which were called lymphosarcomas by the Department of Pathology. May this error be due to our technique of aspirating marrow?

*Dr. Block*: Actually, material obtained at autopsy is practically worthless as far as cytologic study is concerned. The cells must be

fixed immediately or they begin to hollow out, the chromatin begins to clump and the difference between chromatin and parachromatin becomes intensified. In such cases I would ordinarily rely on the material obtained during life. I feel that lymphosarcoma and lymphatic leukemia are essentially similar. The latter involves more tissues and organs, especially the marrow and also gives rise to more lymphocytes in the peripheral blood.

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# Pitfalls in Colon Surgery

**Raymond W. McNealy, M.D., and Francis D. Wolfe, M.D.**
**Chicago**

We propose to discuss some phases of large bowel surgery which offer opportunities for error in judgment as well as in technical management.

The most frequent complication of malignancy in the colon is the development of some degree of obstruction. While it is true that most patients with this condition give a history of digestive upsets and changes in bowel habit, nevertheless, the occurrence of obstruction may be of such suddenness as to cause panic in the patient and family and occasional discomposure in the doctor—a situation which too often leads to ill-advised and ill-timed surgical intervention.

In our experience, it is most unusual to subject a patient to immediate operation. The methods of decompressing the large bowel find greater and greater usefulness as the surgeon becomes more familiar with the various technics which can be employed under these circumstances.

Too much emphasis cannot be placed on the use of nasal suction by the Wangensteen method or the Miller-Abbott tube. It is frequently stated that these suction methods will decompress the small bowel but will have little influence beyond the ileocecal valve or the area between it and the obstructing lesion beyond. Fluoroscopy has demonstrated that very few ileocecal valves are actually competent. Most of them permit regurgitation of gas and liquid from the large bowel into the terminal ileum.

The rather common excuse for an ill-advised emergency laparotomy is that there is little hope of decompressing the so-called "trapped" segment, which lies between the ileocecal valve and the obstructing lesion. If the lesion is low enough in the left colon to be reached by the proctoscope without much manipulation, one may find it comparatively easy to pass a small rectal tube or even a small catheter carefully through the obstructed segment. With the catheter or small rectal tube in place, one may irrigate and relieve the gaseous distention of the large bowel proximal to the lesion.

One should not attempt the passage of the rectal tube or catheter unless he has had adequate training in proctoscopy. It is alarmingly easy to perforate friable walls.

A very vicious practice, which has resulted in disaster on a number of occasions, is the ill-advised use of pituary-like injections which produce vigorous peristalic movements of the intestines. When the obstruction is located in the left colon and there is distention of the large bowel proximally, the occurrence of vigorous peristalic movements can distend the

cecum to a point where rupture of it's thin wall may occur.

It cannot be denied that some unusual conditions resist all attempts to decompress the large bowel either from below or above. For these patients one should plan a method of surgical relief which will be most helpful to the patient, and at the same time not handicap the surgeon in any future operation which may be necessary for the radical removal of the obstructing lesion.

It must be remembered that more than 85% of the tumors of the large bowel are found in the sigmoid and rectum. With this in mind, it is obvious that colostomies which have their openings on the left side of the abdomen may seriously impede exposure and exploration of the sigmoid and rectum. Cecostomies or transverse colostomies are farthest removed from the commonly made incisions for resections of portions of the sigmoid and rectum.

In a previous article one of us has described a simple cecostomy which will give adequate decompression in most cases of large bowel obstruction. It is an interesting fact that the relief of distension by cecostomy is usually followed by patency of the obstructing lesion. The edema and inflammatory reactions often subside to a degree which will admit of the passage of gas and fluid through a previously completely obstructed segment.

Irrigation through the cecostomy and through the anus may aid in dislodging small fecal bodies which tend to plug the narrow lumen. One irrigation is not an efficient test of the method because it is sometimes necessary to repeat the irrigations two or three times a day for several days before one is rewarded by the passage of gas and liquids through the normal channel.

We have been impresed by the local changes in and about the carcinoma which follows the employment of decompressive measures. Many surgeons maintain that a Mikulicz type of operation offers unusual advantages in the obstructed or partially obstructed large bowel. The very suggestion that this operation can be employed in patients with partial or complete obstruction has led to many injudicious interventions. In these cases the tumor is mobilized and the mesentery divided, one cannot avoid cutting across lymph channels which drain the inflamed infected tumor area. The manipulations which must be indulged in during the mobilization of the tumor tend to contaminate liberally the site of operation.

Any attempt to suture the parallel loops above and below the exteriorized tumor is fraught with great danger because of the friable nature of the thin distended segment proximal to the obstructive lesion. The amount of gland bearing mesentery which can be removed safely in a primary resection with end to end anastomosis is greater than with any other type of operation which contemplates restoration of bowel continuity. The fact that the two parallel loops which come to the surface must retain the mesentery which equals the distance from the posterior position of the bowel to the level of the bowel stomata limits the amount of mesentery which can be removed.

Another pitfall for many surgeons is the employment of some type of so-called "aseptic method" of anastomosis following resection of a malignant tumor of the colon.

We would like to express our views and call attention to several serious defects in the technic employed in these operations. Most of the operations of the aseptic type are done over specially designed clamps which hold the crushed ends of the two segments within their grasp. We have repeatedly called attention to the danger of crushing issues which are to become a part of a line of anastomosis. Crushed tissues are devitalized tissues and thus offer a favorable site for infection, abscess formation and necrosis. Since the crushed tissues extend around the entire circumference of both segments, there is great danger that infection will invade some part of either of these two ends. Add to the already devitalized ends, the employment of a continuous suture around the entire circumference at a short distance above and below the crushed tissue, and you are further jeopardizing the union of these divided ends.

There is added danger in the use of continuous sutures; they tend to constrict the lumen. There is also the danger that a well developed diaphragm may follow the line of anastomosis. In previous reports we have spoken of the difficulty of suturing the large bowel without passing the needle into the lumen at some point in

the suture line. Our experience seems to leave little doubt that the less often we have to employ surgical decompression and the more frequently we can decompress the large bowel by non-surgical methods, the better our results will be.

A bowel which is not distended and one whose bacterial flora has been reduced by suitable bacteriostatic drugs, should offer favorable results if the healing capacities of the tissues are not interfered with by technical trauma.

There is the further requirement that the general healing power of the patient be brought to the highest level by all of the modern methods of preoperative preparation. When these requirements are met, there seems to be little doubt that primary resection with immediate end-to-end suture of the large bowel can be employed in most of the accessible regions.

Our experience leads us to the conclusion that over-suturing and excessive infolding at the suture line, associated with devitalizing continuous sutures, are the greatest obstacles to successful repair in large bowel surgery.

No paper dealing with this type of surgery should fail to emphasize the importance of tissue healing. The more completely we are acquainted with the physiology of tissue repair and regeneration, the better foundation we shall have for our operative technic and pre and postoperative care.

Certain measurable indices have been established with some accuracy by which we can predict the healing capacities in a given case. Vitamin C levels in the blood offer a fair index of the connective tissue healing efficiency. Patients with blood levels of less than .70 mg. per cent are not considered good risks. Those whose blood proteins are less than 6.5 mg. per cent are likely to be delayed in their recovery.

In most patients with normal or nearly normal tissues an end to end anastomosis will be at its weakest sometime between the 4th and 8th post operative day. During the first three days, if the suture line is mechanically well approximated, the sutures themselves will keep the tissues firmly united within their grasp. The plastic exudate will cement the area between the sutures but true tissue regeneration will not have taken place. After the fourth day the tissue within the grasp of the suture will have undergone ischemic necrosis but tissue regeneration will not as yet have made itself felt to any degree. It will thus be seen that from the 4th day on, the efficiency of the suture is lessening, and it will be necessary for the tissue repair and regenerative processes to preserve and complete the union of the two ends of the bowel. Great caution should be taken to protect the suture line from strain during these critical four or five days.

Suction and an indwelling rectal tube will serve to limit distention. Food by mouth is withheld and larger accumulations in the repaired bowel are prevented.

## SUMMARY

The appearance of obstruction in lesions of the large bowel is not the signal for immediate surgery. In most cases the bowel can be decompressed by judicious use of suction from above and irrigation from below. Surgical decompression should be thoughtfully designed to facilitate subsequent surgery. The Mikulicz operation should rarely be used. Sound principles should govern the use of suture repair of the colon. Aseptic methods are less in demand without bacteriostatic drugs. Tissue crushing of the bowel ends is a deterrent to early union. The value of improving the general healing capacities of the individual patient cannot be overemphasized. Knowledge of the healing cycle in united intestines must govern the employment of decompression measures and suggest the limitation of liquid and food intake by mouth.

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

# Resection of the Liver for a Hamartoma

**Edward Kallal, M.D., Resident in Surgery**
**and**
**David Movitz, M.D., Associate in Surgery**

There are very few reported cases of resection of the liver for solitary hamartomas. The following case report is of a patient with a tumor-like enlargement in the left lobe of the liver which was resected and which, on microscopic study, proved to be a solitary hamartoma.

A 67-year old white male, Admission No. 50773, a baker, entered Cook County Hospital on January 4, 1950, with the complaint of an epigastric mass which was first noticed by the patient three weeks previously. This had gradually enlarged in size. Epigastric pain accompanied the appearance of the mass, and was most distressing when the patient bent over. The pain was non-radiating, and bore no definite relationship to food-taking. There was no anorexia, nausea nor emesis, and no abnormal stools, except for a diarrhea of short duration. A weight loss of only five pounds in the past year was incurred. There was a past history of genito-urinary symptoms relieved by a supra-pubic prostatectomy at Cook County Hospital approximately 10 years ago.

Physical examination revealed a thin, elderly-appearing, not acutely ill, cooperative white male, whose temperature was 98.6°, pulse 80, and respiration 16 per minute. The blood pressure was 150/80. The teeth were carious. The chest was emphysematous, and a marked dorsal kyphosis was present. The lungs were clear. The heart borders were within normal limits. Rhythm was regular; no murmurs or thrills were present. The second aortic sound was more intense than the first. The abdomen, on inspection, was scaphoid, and presented a symmetrical, globular protrusion in the epigastrium. On palpation, this mass measured about 10cm. in diameter, was rounded, smooth, firm and was not tender. It moved with respiration, and could not be delineated definitely from the liver by palpation or by percussion. The liver was palpable down to one cm. beneath the costal margin. The spleen and kidneys were not palpable. Abdominal tenderness elsewhere and rigidity were absent. No herniae were noted.

From the Surgical Service of Dr. L. M. Zimmerman Department of Surgery, Chicago Medical School.

There was a healed midline suprapubic scar. Peristaltic sounds were of the usual frequency and quality. The genitalia were those of a normal adult male. The extremities presented no unusual changes. Rectal examination was negative, and reflexes were physiological.

Laboratory studies revealed a hypochromic anemia with hemoglobin of 36 percent. The erythrocytes numbered 2.53 million per cu. mm.; the white blood cell count was 15,100 per cu. mm.; the differential revealed 79 percent polymorphonuclear neutrophils, 6 percent lymphocytes, 12 percent monocytes, and 3 percent bands. Cephalin flocculation, 0; Thymol turbidity, 2.6 units; Gamma turbidity, 8.4 units; Total proteins, 6.4 gms. percent; Cholesterol, 95 mg. percent with 34.6 percent esters; Alkaline phosphatase, 2.44 units; Icterus index, 5 units. The nonprotein-nitrogen varied from 26 to 34 mg. percent. Free hydrochloric acid was present in fasting gastric content without histamine. Stool cultures were repeatedly negative for pathogens. Occult blood was persistently 3 plus to 4 plus. Urinalysis revealed specific gravity 1.013; trace of albumin; no sugar. The microscopic was negative.

X-ray studies revealed a normal chest. A flat film of the abdomen was interpreted as within normal limits except for the liver shadow which appeared to be slightly increased in size. Osteoarthritic lipping of the lumbar vertebrae with sacralization of lumbar-5 was noted. Barium meal study revealed a normal esophagus. The stomach filled and emptied satisfactorily. The rugal pattern of the stomach was undisturbed. There appeared to be an extrinsic pressure, however, against the lesser curvature. The duodenal bulb and upper small bowel appeared within normal limits. Barium enema studies, which were repeated, revealed no definite pathology. The transverse colon appeared to be displaced slightly downward in its middle third.

Gastroscopy was interpreted as revealing a picture compatible with an extrinsic mass impinging on the lesser curvature. The angulus incisura was apparently seen, but the antrum and lesser curvature were not visualized due to the fact that the mucosa pressed toward the objective. The mucosa of the posterior wall appeared slightly pale. Proctoscopic examinations revealed no pathology.

During the hospital course, the patient was afebrile. The diarrhea, present on entry, cleared spontaneously a short time after admission and the white blood count returned to normal. The patient was prepared for exploratory operation with multiple blood transfusions and oral sulfasuxidine. On February 27, 1950, laparotomy was performed (L. M. Z.) through a high left paramedian incision. A firm, apparently smooth density in the substance of the inferior margin of the left lobe of the liver was encountered. It was situated at the base of the falciform and round ligaments and was exposed by severing these ligaments from the liver. The gastrointestinal tract, spleen and extrahepatic billary tree were normal on exploration.

The mass was resected after circumventing it with through and through mattress sutures. The remaining gaping liver edges were then approximated. The abdomen was closed in layers.

The mass, on section, presented dense grayish fibrous tissue with softer areas and a grayish liquified center, whose cavity was lined by a smooth grayish wall. The fluid was sent to the laboratory for culture and was subsequently reported as negative for pathogens.

The post-operative course was entirely uneventful. The patient became afebrile on the fourth post-operative day and was discharged from the hospital on the tenth post-operative day without any complaint.

The pathologist, Dr. Alex B. Ragins, reported the specimen as follows: Specimen consists of a portion of liver measuring 8 x 4.5 x 5 cm. and covered by firm fibrous adhesions and ligamen-




**Figure 1. Low power section through hamartoma of liver, A. Cystic cavity in portion of the mass.**

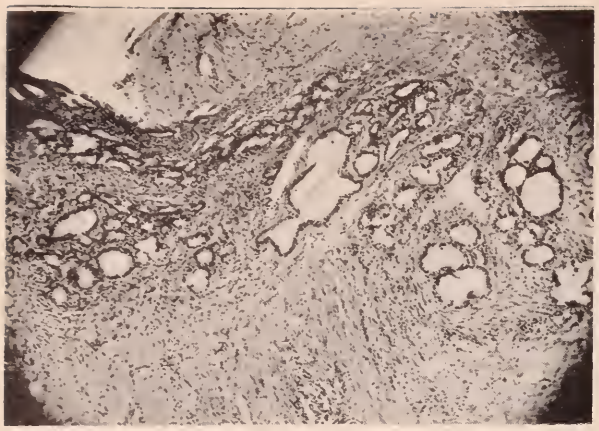


**Figure 2. Photomicrograph showing connective tissue, blood vessel and bile duct proliferation.**

tum teres. On sectioning, there are numerous gray, firm areas measuring up to 2 cm. in diameter. Microscopic: a hamartoma of the liver, characterized by proliferation of bile ducts, connective tissue, and blood vessels. (Figure 2)

## DISCUSSION

The term hamartoma was first proposed by Albrecht[1] to designate tumor-like enlargements which are due to errors in development, and which are considered to be non-neoplastic in nature. They consist of normal histologic elements, but in abnormal mixture. The proportion of fibrous tissue is usually distinctly increased. These lesions possess a limited capacity for aberrant growth.

In his original presentation, Albrecht reported a hamartoma of the liver which was mainly hemangio-cavernomatous, and one of the kidney of a fibro-canalicular variety. They have also been observed in the lung, in the gastrointestinal tract, in the brain arising from its blood vessels, and as disseminated lesions within certain anatomical systems such as the skin or the nervous system. Hamartomas are rather uncommon, and the greatest number has been noted in the lung.

In the liver, most hamartomas are seen as small hemangiomatous enlargements which are found incidentally at autopsy. Solitary lesions are found in normal livers, and multiple ones in cirrhosis. Clinically, hamartomas of the liver occur most often in infants and young children, although our case was in an elderly male. They are variable in size and present as small or large upper abdominal masses, particularly in the epigastrium and right upper quadrant. They usually require pyelograms and gastro-intestinal x-ray studies for their localization. They may remain stationary in size for some time, confirming their limited capacity for aberrant growth.

The right lobe of the liver is the most often involved, but hamartomas occur in the left lobe, or in the caudate lobe, and even both lobes have been reported to be involved. Liver hamartomas have been resected successfully and reported in three previous instances. Ladd and Gross[2] in 1941 reported the successful removal of a hamartoma in the right lobe of the liver of an 8-month old infant. Benson and Penberthy[3] reported in 1942 a successful resection of a hamartoma in a 7-month old infant. Patton[4] in 1948 resected nearly half of the right lobe of a liver in a 16½-month-old female infant and removed a hamartoma measuring 8 x 7 x 4 inches. The infant recovered uneventfully. We are adding a fourth case of resection of a liver hamartoma with uneventful convalescence. In the case of Kay and Talbert[5] a large nodular tumor replaced the left lobe and half of the right lobe and thus could not be removed. The tumor had been present for about two years before the biopsy, and two years after biopsy the patient still remained well. This tends to confirm the non-neoplastic character of this entity.

The patient presented here experienced a gradual but marked reduction in the size of the epigastric mass during the preoperative hospital stay. This reduction in the size was apparently due to a reduction in the quantity of cystic contents within the hamartoma. As demonstrated

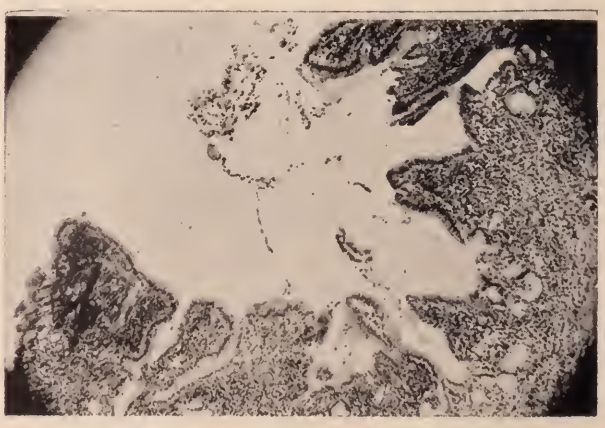


**Figure 3. Cyst within hamartoma lined with bile duct epithelium in papillary formation.**

by the photomicrograph, this cystic portion was lined by papillary formation of bile duct epithelium (Figure 3). The case of Patton also revealed a cystic formation[4].

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## NERVOUSNESS INHERITED

We are only now beginning to understand how devastating parental anxieties, whatever their source, are to the child's peace of mind. Many factors may be responsible for this state of affairs: the radio, magazines, newspapers and books on child rearing may contribute to the parent's feeling of inadequacy. These feelings are often reinforced by the conflicting opinions of "experts" regarding basic principles of child rearing. Perhaps our own lack of understanding of this problem may also be important. It is safe to assume that parental insecurity is far more common in our culture than has been generally recognized. Huschka and McKnight, working in a well-baby clinic, found all but 5 mothers out of 57 "had complaints in regard to their babies." In 3 of the remaining 5, maternal anxieties "were interfering with emotional development of the child." Langford reports the incident of a fourth year medical student who spent two hours taking a history and examining a child brought to the clinic because of "nervousness." Unable to discover the cause he appealed to the instructor, who, through a single question, found the mother was suffering from a paranoid psychosis. He adds the mother "who brings in her child for a physical disorder is often equally as revealing of the concerns, worries and preoccupations which have emotional significance for her and for the child." Further, the mother may carry over into her relationships with her child "unresolved conflicts in her relationship with her own parents." The recognition of parental insecurity as it relates to the problems of children and helping parents deal with it, presents many opportunities for promoting mental health. *Excerpt: The Physician and Mental Health, Reynold A. Jensen, M.D., Minneapolis, The Wisc. Med. J., June 1950.*

# NEWS OF THE STATE



## ADAMS

**Medical Society Celebrates Centennial.**—A public celebration will mark the one hundredth anniversary of the Adams County Medical Society in October. The observance will feature exhibits of the advances made in medicine during the past century, an historical pageant depicting the advance in medical science, a parade and a prominent speaker. Everything will be open to the public. There will be no charge except for the admission to the pageant itself. In announcing the observance, Dr. Harold Swanberg, general chairman of the project, said that the Adams County Medical Society will underwrite the cost as a public service activity.

## BOONE

**Personal.**—Dr. Bernard E. O'Malley, Belvidere, was recently appointed city health officer.

**Ninety Years of Age.**—Dr. A. W. Swift, Belvidere, observed his ninetieth birthday July 16. Dr. Swift, who is now in retirement because of ill health, practiced medicine in Belvidere for sixty-five years. With the exception of six years, he has been a lifetime resident of Boone county. He once served as mayor.

## CHAMPAIGN

**Golden Anniversary Wedding.**—An open house marked the golden wedding anniversary of Dr. L. O. Sale and his wife, Margaret, recently. Dr. Sale has been practicing in Champaign county for fifty-four years. Dr. Sale is a former president of the Champaign County Medical Society.

**Personal.**—Dr. G. F. Whitlock of the Carle Hospital clinic staff was chosen president of the Champaign-Urbana Camera Club recently.

## CRAWFORD

**Dr. Kirk at County Fair.**—Dr. J. W. Kirk, who has practiced medicine for fifty-two years in Oblong, was honored September 7 on "Dr. Kirk Day" at the Crawford county fair.

## FULTON

**Dr. Davis Honored.**—Dr. E. E. Davis, Avon, was recently presented with the Fifty Year insignia of the Illinois State Medical Society, indicating his completion of fifty years in the practice of medicine. The presentation of the insignia was made by Dr. Andy Hall, Mount Vernon. Other speakers were A. W. Ray, Avon, 43rd district legislator, and Dr. C. Paul White, Kewanee, President-Elect of the Illinois State Medical Society. Dr. A. C. Bagge, Avon, president of the Fulton County Medical Society, presided.

## COOK

**Society News.**—Dr. Leon Unger recently addressed the Rock Island County Medical Society on "The Treatment of Bronchial Asthma" and discussed "Migraine" before the Annual Laity Day meeting of the medical auxiliary in Moline.

**Personal.**—Dr. George Halperin, associate editor of the Journal of the American Medical Association and editor of its current medical literature department, has been elected president of the seventy-seven-year-old Chicago Literary Club. His term begins October 9.—Dr. Loyal Davis, Grunow professor of surgery and chairman of the department at Northwestern University Medical School, has been selected to represent the American College of Surgeons in the division of medical science on the National Research Council, it was announced July

25. Dr. Davis' appointment is for a period of three years.—Dr. David A. Willis, associate professor of surgery, Chicago Medical School, and attending surgeon, Mount Sinai Hospital, has been awarded a European Traveling Fellowship by the World Health Organization of the United Nations. The fellowships are awarded for the purpose of observing and studying medical educational methods in a number of European countries, the itinerary for which is arranged by the Geneva office of the World Health Organization. Dr. Willis will leave Chicago in September for a period of three months.—Dr. Harwell G. Davis Jr., Birmingham, Ala., has been appointed director of laboratories at Evanston Hospital.

**Personal.**—Appointment of Mrs. Hale C. Pragoff as medical social work consultant to the National Society for Crippled Children and Adults has been announced by Lawrence J. Linck, executive director. Society office headquarters are located at 11 South La Salle Street, Chicago 2. As medical social work consultant, Mrs. Pragoff will interpret specific needs of the handicapped to other national organizations for the National Society in the development of medical social services.

**Special Society Elections.**—At the annual meeting of the Chicago Society of Internal Medicine, May 22, the following officers were elected: Dr. Howard L. Alt, president; Dr. Frank B. Kelly, vice president; Dr. Ernest G. McEwen, secretary-treasurer; and Drs. Henry T. Ricketts, George H. Coleman and Sidney Strauss, executive committee.—The Chicago Gynecological Society elected the following officers at its annual meeting June 16: Dr. John I. Brewer, president; Dr. M. Edward Davis, president elect; Dr. Paul C. Fox, vice president; Dr. Fred O. Priest, treasurer; Dr. Edward M. Dorr, secretary; Dr. Alfred J. Kobak, pathologist and Dr. Lester D. Odell, editor.

**The Volini Laboratories.**—The Hektoen Institute for Medical Research of Cook County Hospital has named its antibiotic laboratories the Volini Laboratories in honor of the late Dr. Italo F. Volini.

**Robert Kark Promoted.**—Dr. Robert M. Kark has been promoted to the rank of professor of medicine at the University of Illinois College of medicine. He has been serving as associate professor of medicine and also as chief of clinical investigation of the U. S. Army Medical Nutrition Laboratory of Chicago.

**Coordinator of Cancer Teaching Program Named.**—Dr. Philippe Shubik, a graduate of the University of Oxford, has been appointed to the faculty of the Chicago Medical School as coordinator of the cancer teaching program, it was announced recently.

Dr. Shubik taught pathology at the Sir William Dunn School of Pathology, Oxford, and at the same time was engaged in cancer research, working on the mechanism of artificial production of tumors in animals. Since last June he has been teaching and doing cancer research at Northwestern University.

Under Dr. Shubik's direction, additional courses on newer methods of the diagnosis of cancer and their evaluation will be set up at the school. Also, short courses on experimental work in cancer, with careful consideration of all the newer therapeutic agents in use for cancer. A new cancer research unit will be set up, and all teaching related in any way to cellular growth will be carefully studied, and recommendations put forward to ensure that the students will have the background necessary for a full understanding of the cancer problem.

Future plans include the establishment of a system through which the occupational backgrounds of cancer patients coming through the School clinics will be studied and recorded — this to be combined with research activities.

**University News.**—Dr. Arthur F. Mead has been awarded the 1950 Leo F. Miller prize at the University of Illinois College of Medicine for his extensive study in the field of orthopedic surgery. Awarding of the prize, which carries a fifty dollar stipend, was announced by Dr. Fremont A. Chandler, professor and head of the department of orthopedic surgery. The prize-winning study was entitled "Orthopedic Implications of Fluorine."—The appointment of Dr. W. Glen Moss as an assistant professor of physiology at the University of Illinois College of Medicine has been announced by Dean Stanley W. Olson. Dr. Moss received his bachelor of arts degree from the University of Wichita, his master of arts degree in physiology from the University of Chicago, and his doctor of philosophy degree in physiology from the University of Illinois. Between 1942 and 1948, Dr. Moss performed research and served as an instructor in the department of physiology at the University of Illinois, contributing extensively to the field of experimental hypertension, particularly regarding the role of renal extracts and the nervous system. Prior to his present appointment, Dr. Moss served as an associate professor of pharmacology at Temple University School of Medicine.—New faculty appointments at the Chicago Medical School include Dr. Jacob S. Fishman, associate in medicine; Dr. Milton M. Kadin, assistant in medicine; and Dr. Morris D. Bennin, assistant in opthalmology. Dr. Solomon C. Werch has been appointed assistant professor of medicine and will serve also as director of the dispensary as well as director of teaching of the residents and internes at Mount Sinai Hospital. Dr. Werch recently came from the University of Colorado College of Medicine where he served as head of the department of medicine at one of its teaching hospitals.

**Research Award Established.**—An Annual Meritorious Research Award has been established for the Chicago Medical School by an anonymous friend. The award, amounting to two hundred fifty dollars will be given to a faculty member who is considered to have done the most outstanding research work in the year's period. Dr. Leo B. Zimmerman is chairman of the committee which

is responsible for determining to whom the award shall go.

**Research Grants.**—Three new research grants amounting to $15,265 have been awarded to the Chicago Medical School. One, an extension grant of $14,000 for the program of cardiology, was awarded by the U. S. Public Health Service upon recommendation of the National Heart Institute. Another, in the amount of $825 has been received from the committee for research in problems of sex of the National Research Council. This grant will be used by Dr. George Clark for a study on the role of the hypothalmus in sex behavior. The other grant of $440 from the Veterans Administration will also be used by Dr. Clark for a research problem on the use of domestic protargol in staining nerve endings in gums and teeth.—The U. S. Public Health Service has awarded three research grants in the total amount of $35,936 to the University of Illinois College of Medicine. A continous grant in the amount of $15,000 has been received for the study of the effects of the betatron. Previous aid has been used for the investigation of the x-ray beam of the betatron and the continuation grant will be used in support of the investigation of the electron beam on bone and cartilage. The study is under the supervision of Dr. Roger A. Harvey and G. A. Bennett. Dr. Klaus R. Unna has received a $13,610 grant in support of a study concerning the site of action in the central nervous system of drugs useful in spastic conditions. A continuation grant in the amount of $7,326 has been given to Dr. David Shakow for the analysis of psychological data on schizophrenia.

**Public Health Institute.**—The University College of Northwestern University and the United States Public Health Service held an Institute in Administration for Public Health Officials at Abbott Hall, 710 Lake Shore Dr., Chicago, July 17 to 29.

The Institute dealt with administrative problems and trends encountered by public health physicians. The program included lectures by specialists, group discussion, interest conferences, and special problem seminars.

Instructors and discussion leaders included members of the Northwestern faculty and specialists in public relations, personnel management, business administration, municipal government and community sociology.

Among these specialists were Dr. Hugh Duncan, specialist in sociology; David Cox, public relations consultant; Dr. Charles S. Hyneman, professor of political science; Dr. Franklyn S. Haiman, instructor in public speaking; Dr. A. C. Van Dusen, associate professor of psychology and director of the summer sessions; Dr. Myron H. Umbreit, director, evening division, School of Commerce. Dr. E. T. McSwain, Dean of the University College, was the coordinator.

## MADISON

**New Township Officers.**—Dr. B. L. Roberson, Wood River, was recently installed as president of the Wood River Township Medical Society, succeeding Dr. Maurice Woll. Other officers are Dr. H. S. Mendelsohn, vice president; and Dr. Anthony Sammis, secretary treasurer.

**Groves Smith Host to County Society.**—Dr. Groves B. Smith, superintendent and medical director of Beverly Farm, Godfrey, was, with his wife, host to the Madison County Medical Society and their families. The evening included a buffet supper and fireworks.

## MORGAN

**New Health Officer.**—Dr. James W. Chapman has been named director of the Morgan County Health Department, effective July 1. Dr. Chapman was formerly in charge of two state districts, fifteen and sixteen, and previously worked in Michigan, Missouri, Tennessee and California.

## JEFFERSON

**Hospitals to Handle Wednesday Afternoon Calls.**—The Jefferson-Hamilton County Medical Society announced recently that all calls by persons requiring the services of physicians on Wednesday afternoons should be made to either Good Samaritan or Jefferson County Memorial Hospital, according to the Mount Vernon Register-News. The hospitals will establish registries to handle emergency medical service calls on the half-days the physicians close their offices.

## PIKE

**Personal.**—Dr. and Mrs. W. W. Kuntz, Barry, observed their golden wedding anniversary, July 4. Dr. Kuntz has been practicing in Barry for about thirty years, having previously served in Baylis.

## SANGAMON

**Personal.**—Dr. William H. McCain, formerly of Pana, has been appointed physician at St. John's Sanatorium. He will reside in Springfield.

## WINNEBAGO

**Personal.**—Dr. John T. Small, Rockford, recently gave up his practice to accept a position as head of thoracic surgery at Olive View Sanatorium, Los Angeles.

## HEALTH DEPARTMENT ACTIVITIES

**Health Department Reorganized.**—The first step in the reorganization of the state Department of Public Health to achieve greater efficiency and economy became effective August 1 when the department's present fifteen divisions were merged into six such units. Announcing the planned reorganization recently, Dr. Roland R. Cross, state director of public health said:

"An important end in view in the reorganization is improved efficiency and economy. Although the new groupings will probably be permanent, they are subject to changes which may be necessary to conform with recommendations not yet made by the Schaeffer Commission."

Under the new organization, the health department divisions will include the Division of General

Services, under B. K. Richardson who is now senior administrative assistant to Dr. Cross; Division of Personal Health Services, under Dr. Leonard M. Schuman, present acting chief of communicable diseases; Division of Hospital and Institutional Services, headed by Dr. G. Howard Gowen, present chief of the division of Cancer Control; Division of Local Health Services, under Dr. C. F. Sutton, who is now chief of the same division; Division of Environmental Health Services, under C. W. Klassen, present chief of the division of sanitary engineering; and the Division of Laboratory Services, which will remain under the direction of H. J Shaughnessy, Ph.D.

Health agencies which will fall under the Division of General Services will include the Bureaus of Public Health Dentistry, Nursing, Statistics, Public Health Education, Administration, and Hotel and Lodging House Inspection.

The Division of Personal Health Services will include Bureaus of Epidemiology, Tuberculosis Control, Maternal and Child Care, Industrial Hygiene, and Preventive Mental Health Services.

Included in the Division of Hospital and Institutional Services will be the Bureaus of Hospital Planning and Construction, Licensure and Inspections, Cancer Control, and Heart Disease Control.

The Division of Local Health Services will coordinate activities of five regional health offices covering the state, and will maintain liaison with all local health departments.

Under the Division of Environmental Health Services will come Bureaus of Public Water Supplies, Stream Pollution, General Sanitation, and Milk and Food.

The Division of Laboratory Services will include Bureaus of Diagnostic Services, Sanitary Bacteriology, Biologic Products, Laboratory Evaluation, and Virus Diseases and Research.

The reorganization follows, in general, recommendations made by the United States Public Health Service, which recently completed an extensive survey of the organization and operations of the state health department.

## MARRIAGES

Dr. Albert Lee Spaulding Jr. to Mrs. Marva Trotter Louis, both of Chicago, May 20.

Dr. Herbert Janson, Homewood, to Miss Mary Filson of Matteson, in Chicago, May 27.

## DEATHS

Arsen S. Artin, Enfield, who graduated at Northwestern University Medical School in 1899, died July 12, aged 77. He had practiced medicine in Enfield for 46 years.

Gilbert R. Brewer, Stonefort, who graduated at George Washington University School of Medicine in 1912, died July 3, aged 71. He had practiced medicine for 37 years, had served as mayor, and for many years as member of the school board.

Leila DeEtte Jackson, Evanston, who graduated at Rush Medical College in 1908, died May 23, aged 77

George H. Flickinger, Hopedale, who graduated at Chicago Medical School in 1934, died July 10, aged 46. He had served in the Medical Corps in World War II, and was a past president of Tazewell County Medical Society.

Millard M. Fowler, Marion, who graduated at the University of Tennessee Medical Department, Nashville, in 1897, died April 5, aged 79.

William J. Garard, retired, Chicago, who graduated at Chicago Homeopathic Medical College in 1903, died July 25, aged 75.

Eslie Helen Hartman, Chicago, who graduated at New York University College of Medicine in 1942, died in a plane crash recently, aged 34. She was clinical instructor in medicine and medical adviser for women in the Health Service at the University of Illinois College of Medicine.

Harold E. Jones, Chicago, who graduated at Northwestern University Medical School in 1909, died July 10, aged 63. He was senior attending surgeon at St. Luke's Hospital.

Effie L. Lobdell, Chicago, who graduated at Fort Wayne College of Medicine in 1892, died August 8, aged 83. She was formerly on the staff at Grant Hospital.

John David McDonald, Alton, graduated at St. Louis University School of Medicine in 1930; he was affiliated with Alton Memorial Hospital and St. Joseph's Hospital, where he died June 2, aged 44.

Charles H. Ruch, Momence, who graduated at Indiana University School of Medicine in 1926, died August 2, aged 54. He had been city health officer of Momence for several years and was a member of the staff of St. Mary hospital.

William J. Schaffer, Chicago, who graduated at Jenner Medical College in 1908, died August 3, aged 73. He had been examining physician for the Chicago Park District Police Annuity and Benefit Association over 40 years.

Arnold Schimberg, Chicago, who graduated at Northwestern University Medical School in 1927, died July 18, aged 48. He was instructor in surgery at Northwestern, and senior attending surgeon at Wesley Memorial Hospital.

Frank J. Smejkal, Chicago, graduated at the University of Illinois College of Medicine in 1926, died August 4, aged 60. He was associate professor of medicine at Chicago Medical School, former senior physician at the Municipal Tuberculosis Sanitarium, and a member of the State Tuberculosis Board.

Edward S. Stewart, retired, Plainfield, who graduated at Northwestern University Medical School in 1892, died July 27, aged 88. He had practiced on Chicago's south side for 46 years before moving to Plainfield.

Frank J. Theobald, Cary, who graduated at the University of Illinois College of Medicine in 1906, died July 28, aged 67. He had practiced medicine in Lake County for 46 years.

Frank S. Tufts, retired, Chicago, who graduated

at the University of Illinois College of Medicine in 1903, died July 12, aged 78.

Rudolph F. Tussing, Chicago, who graduated at Northwestern University Medical School in 1936, died July 15, aged 44. He was radiologist and staff member at the Municipal Tuberculosis Sanitarium.

Morris R. Weidner, Sr., Dolton, who graduated at the University of Illinois College of Medicine in 1883, died July 27, aged 93. He was a member of the "Fifty Year Club" of the Illinois State Medical Society and an emeritus member of the Chicago Medical Society and the University of Michigan Alumni Association.

Levi J. Weir, Marshall, who graduated at the Kentucky School of Medicine, Louisville, in 1893, and Rush Medical College in 1896, died June 28, aged 80, of a cerebral accident. He was a member of the Aesculapian Society of the Wabash Valley.

Clarence P. Wikoff, retired, Bloomington, who graduated at Rush Medical College in 1893, died July 10, aged 81.

Orville Wilhelmy, Decatur, who graduated at Barnes Medical College, St. Louis, in 1907, died July 17, aged 66. For the past 30 years, he was surgeon for the Illinois Power Company and the Illinois Terminal System; he was a past president of the Macon County Medical Society.

# "FOR THE COMMON GOOD"

**Lectures Arranged by the Educational Committee of the Illinois State Medical Society:**

Lawrence Breslow, Austin Town Hall in Chicago, August 16, on Health Questions Your Pals Ask.

George M. Cummins, Chicago, Winnebago County Home Bureau Units, August 24, Physiologic and Mental Aspects of Geriatrics.

Stanley Stanmar, La Salle, Lacon Woman's Club in Lacon, September 15, on Growing Old Gracefully.

Hugo R. Rony, Chapter AD, P.E.O. Sisterhood, in Chicago, October 2, How Old Is Old?

Lawrence Breslow, Henry H. Nash School P.T.A., in Chicago, October 4, Together We Learn —Through Health.

Paul K. Anthony, Marquette School PTA, October 16, in Chicago, Growth Toward Maturity".

Irving Mizell, Belding PTA in Chicago, October 17, Summer Roundup: What It Means to You.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

Edwin R. Levine, Chicago, La Salle County Medical Society in La Salle, October 12, on Chest Diseases in Office Practice, illustrated.

E. Harold Ennis, Springfield, Whiteside-Lee County Medical Societies in Sterling, October 12, on Use of Estrogens.

John L. Keeley, Chicago, Iroquois County Medical Society in Watseka, October 17, on Surgical Problems of Infancy and Childhood.

Willard O. Thompson, Chicago, Kankakee County Medical Society in Kankakee, October 24, on Use and Misuses of Sex Hormones, illustrated.

Ralph H. Kunstadter, Chicago, Dekalb County Medical Society, October 24, on Problems of Diarrhea in Infancy, illustrated.

Arkell M. Vaughn, Chicago, McDonough County Medical Society in Macomb, October 27, on Surgical Treatment of Varicose Veins, illustrated.

**Radio**

Your Doctor Speaks over WFJL, Thursday evening, at 7:15, carried the following physicians in transcribed broadcasts:

Carroll Birch, August 3, Ancestors and Heirs.

Edward A. Piszczek, August 10, Infantile Paralysis.

Clement Martin, August 17, Rectal Diseases.

Lindon Seed, August 18, on Goiter.

Harry Oberhelman, August 31, on Gallbladder Disease.

Charles S. Gilbert, September 7, on Diet and Disease.

Lowell T. Coggeshall, September 14, on The Common Cold.

"You and Your Baby" over Station WAAF, Tuesday mornings at 10:30 a.m. presented the following physicians in "live" broadcasts:

John M. Reichert, August 1, Taking the Baby Home.

Eugene T. McEnery, August 8, on Breast Feeding.

Eva J. Line, August 15, The Bottle Fed Baby.

A. Alvin Wolf, substituting for Joseph Greengard, August 22, Baby's First Month.

Here Is Your Doctor over Station WCFL, Sunday mornings, at 11:45 a.m., presented the following physicians in transcribed broadcasts:

William P. Swisher, Evanston, August 6, on What Is A Case History.

Philip Lewin, August 13, on Poliomyelitis.

"us doctors agree Eskadiazine tastes better"

Patients of all ages take Eskadiazine willingly—it is so good tasting, so light, so easy to swallow. Furthermore, Eskadiazine *acts faster* because it contains—instead of ordinary sulfadiazine—S.K.F.'s microcrystalline sulfadiazine in a stabilized suspension. With Eskadiazine desired serum levels may be attained 3 to 5 times more rapidly than with sulfadiazine in tablet form. No wonder Eskadiazine stands above all fluid sulfadiazine preparations available today.

Each 5 cc. (one teaspoonful) contains 0.5 Gm. (7.7 gr.) of sulfadiazine—the dosage equivalent of the standard half-gram sulfadiazine tablet.

'*Eskadiazine*' *T. M. Reg. U. S. Pat. Off.*

# ESKADIAZINE

The outstandingly palatable fluid sulfadiazine

*Smith, Kline & French Laboratories, Philadelphia*






While RAYSAL-SUCCINATE contains sufficient salicylic acid for prompt analgesic effect in arthritic and rheumatic patients—it goes beyond the salicylates, since succinic acid is added for therapeutic effect. Succinic acid protects the patient against decrease in blood prothrombin levels and increases the ability of the tissues to utilize oxygen from arterial blood.

The latter action helps eliminate from the tissues those waste products which contribute largely to rheumatic and arthritic pain.

RAYSAL-SUCCINATE is ideally suited as adjuvant treatment to other therapeutic measures employed.

The Safe and Effective Combination for Use in Your Next Case.

*Each "salol" enteric-coated tablet contains:*

Raysal . . . . . 5 grains
(Representing 43% Salicylic Acid and 3% Iodine in Calcium-Sodium Phosphate Buffer Salt Combination)
Succinic Acid . . . . . 2 grains

SEND FOR A FREE CLINICAL SUPPLY

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AVAILABLE AT ALL PHARMACIES ON PRESCRIPTION

*OVER A QUARTER CENTURY SERVING THE PHYSICIAN*

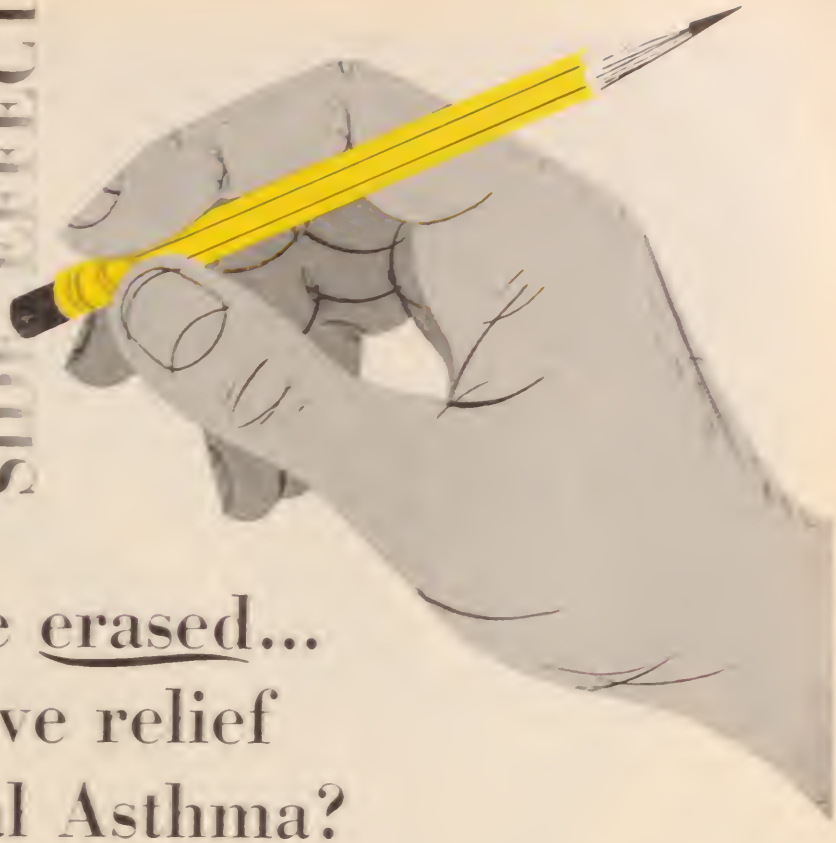
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SIDE EFFECTS



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Yes, there now is a therapy—NETHAPRIN—that gives prompt, symptomatic relief in asthma and associated allergic conditions, *and also is essentially free from the undesirable side actions of ephedrine.*

Clinical tests show NETHAPRIN can be expected to provide effective relief . . . increased vital capacity . . . better feeling of well-being. Yet its bronchodilator, Netlamine, "produces no noticeable pressor action."[1]

# NETHAPRIN®

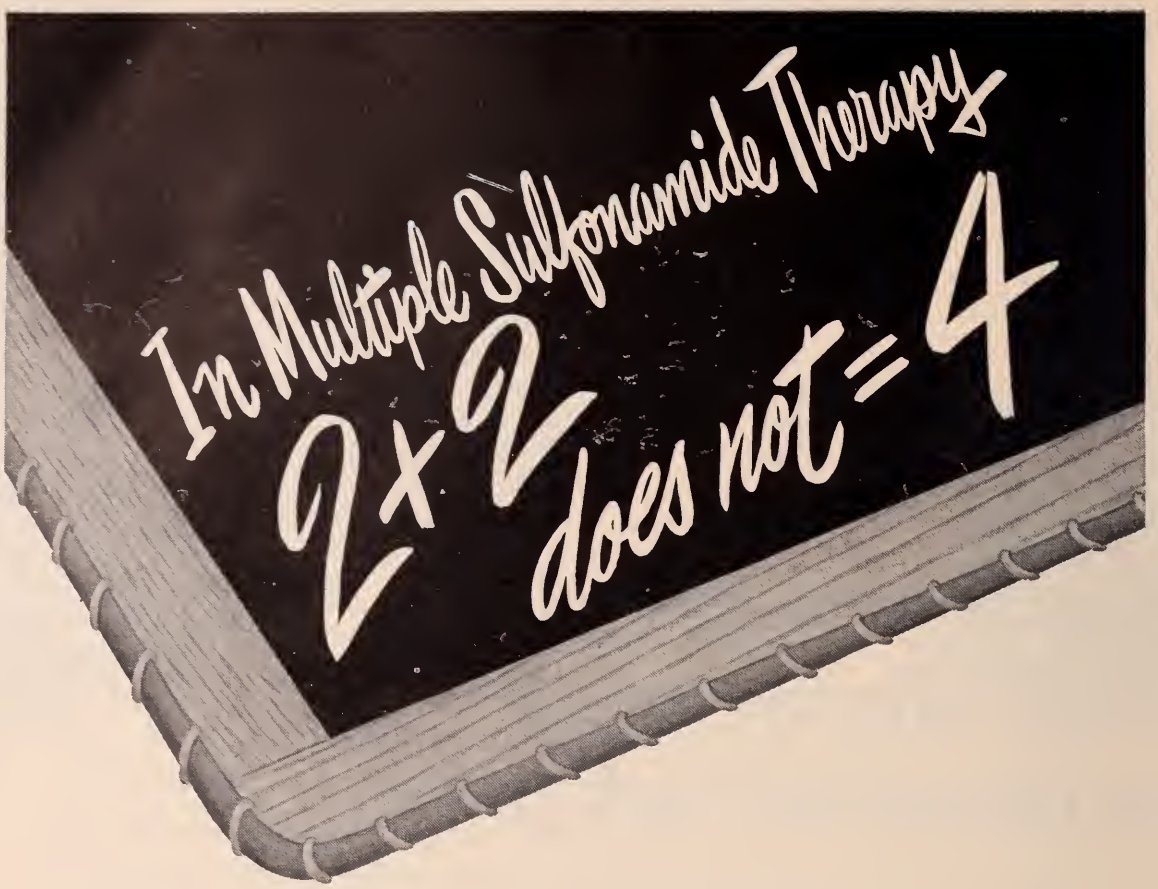
**SYRUP** **CAPSULES**

Each teaspoonful contains: Netlamine® Hydrochloride 25 mg., Butabarbamine® 8 mg., Delaphyl® Succinate 6 mg.

When Phenobarbital is preferred to the antihistamine, prescribe NETHAPHYL®—in full or half strength.

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CINCINNATI • U.S.A.

[1] Russell, T.R.: Ann. Allergy 5:397, 1947




Therapeutic action is additive, but the total urinary solubility of two sulfonamides is significantly greater than that of either alone.

Aldiazol-M, a dual sulfonamide, contains both sulfadiazine and sulfamerazine in microcrystalline form, and the alkalizing salt, sodium citrate. Aldiazol-M increases the field of useful application of sulfonamide therapy because:

*Blood levels are produced more rapidly.* The microcrystalline form of the sulfa drugs is absorbed more quickly, leading to higher initial levels.

*Hazard of renal complications is reduced.* Because of the greater solubility of dual sulfonamide mixture, urinary precipitation is prevented, virtually eliminating crystalluria.

*Greater therapeutic efficacy is obtained.* Aldiazol-M can be given safely in adequate dosage, and effective blood levels maintained in adults on a dosage of 2 teaspoonfuls every four hours.

*Widely indicated.* Aldiazol-M is indicated whenever the specific actions of sulfadiazine and sulfamerazine are required. It is valuable not only in adults, but also in the treatment of many infectious diseases in children.

Aldiazol-M is available on prescription through all pharmacies. Write for literature.

**THE S. E. MASSENGILL COMPANY**
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Each teaspoonful (5 cc.) of Aldiazol-M provides:
Sulfadiazine (microcrystalline)...0.25 Gm.
Sulfamerazine (microcrystalline)...0.25 Gm.
Sodium Citrate..... 1.0 Gm.

Aldiazol-M



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When pain, heartburn, belching, nausea, or unstable colon are due to gastrointestinal spasm, Mesopin provides an effective means for prompt relief. Its selective antispasmodic action on the digestive tract controls spasticity without the undesirable side effects of atropine or belladonna. Thus, symptomatic relief of many common disturbances of the stomach or intestines can be achieved with discrimination and safety. Mesopin is indicated for the relief of gastrointestinal spasticity, such as pylorospasm, cardiospasm, spastic colon, and biliary spasm.

## MESOPIN (brand of homatropine methyl bromide)

**SELECTIVE GASTROINTESTINAL ANTISPASMODIC**

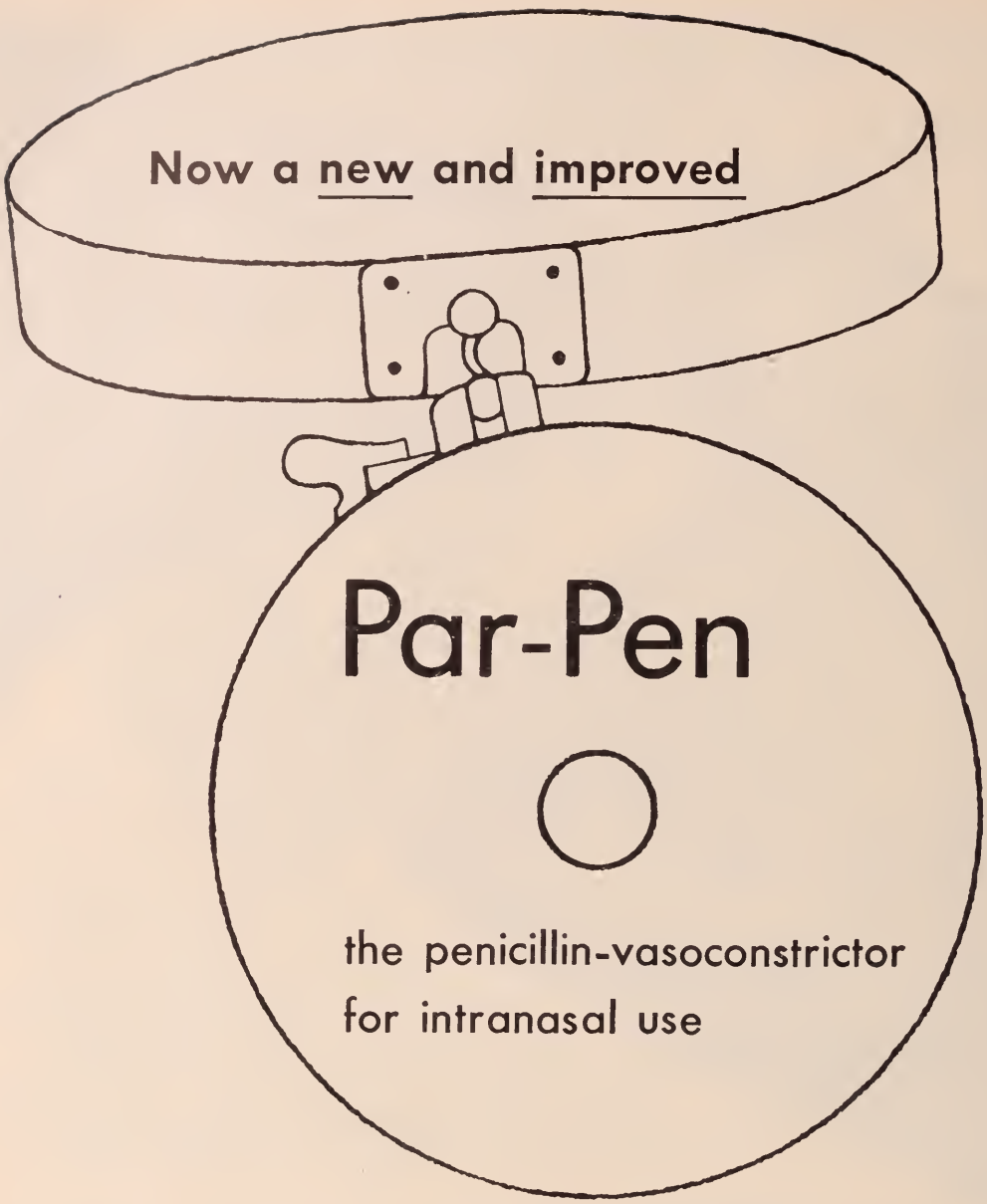
SUPPLY: Elixir in 16 ounce bottles; tablets in bottles of 100.
MESOPIN (homatropine methyl bromide)—2.5 mg. per teaspoonful of elixir or per tablet. Also supplied: MESOPIN-PB*—2.5 mg. Mesopin and 15 mg. (1/4 gr.) phenobarbital per teaspoonful of elixir or per tablet.

*Detailed literature and samples on request.*

Endo®

*PB abbreviated designation for phenobarbital.

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In response to physicians' requests, two major changes have been made in Par-Pen:

**optimal strength:** The strength of Par-Pen has been increased to 5000 units of penicillin per cc.

**convenient size:** The package has been changed to a convenient ½ fl. oz. (15 cc.) bottle—to eliminate wastage.

Par-Pen contains crystalline potassium penicillin G, 5000 units per cc.: Council-accepted Paredrine Hydrobromide (hydroxyamphetamine hydrobromide, S.K.F.), 1%; in a specially buffered isotonic aqueous solution.

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# Nutrition is a Primary Factor



Whether the condition under treatment is an acute infection, a bowel upset, an injury or a metabolic derangement, nutrition is always a primary factor in therapy. Regardless of other indicated measures, nutritional adequacy is essential for prompt recovery.

When dietary supplementation is the indicated means of increasing the nutrient intake, the food drink, Ovaltine in milk, can prove highly beneficial. Providing significant amounts of all nutrients considered essential, it virtually assures dietary adequacy when the recommended three glassfuls daily are taken in conjunction with even a fair diet.

Temptingly delicious and readily digested, this dietary supplement fits well into the framework of most indicated diets, and finds ready patient acceptance. Its generous nutrient content is detailed in the table below.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**




## Ovaltine

*Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:*

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| PROTEIN | 32 Gm. | VITAMIN A | 3000 I.U. |
| FAT | 32 Gm. | VITAMIN $B_1$ | 1.16 mg. |
| CARBOHYDRATE | 65 Gm. | RIBOFLAVIN | 2.0 mg. |
| CALCIUM | 1.12 Gm. | NIACIN | 6.8 mg. |
| PHOSPHORUS | 0.94 Gm | VITAMIN C | 30.0 mg. |
| IRON | 12 mg. | VITAMIN D | 417 I.U. |
| COPPER | 0.5 mg. | CALORIES | 676 |

*Based on average reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

*when a Lozille is dissolved slowly in the buccal sulcus...*



*The antibacterial action is* ***powerful...***

*The antibiotic is* ***nontoxic...***

*The "sore throat" relief is* ***sustained...***

LOZILLES *Tyrothricin-propesin lozenges*

Pleasantly flavored, each Lozille contains 2 mg.—an effective dosage—of tyrothricin, and 2 mg. of propesin for prompt, prolonged analgesia. Bottles of 15.

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# *Handier than ever*

# *new*

## UNIVERSAL MODEL

# CLINITEST

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**urine-sugar analysis set**

**Optional Tablet Refill**
**Sealed in Foil** *(illustrated)*
*or* **Bottle of 36**

- **complete**
- **compact**
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The attractive new plastic case, hardly larger than a cigarette package, includes complete facilities for urine-sugar detection. Your diabetic patients, long accustomed to depend upon the rapidity, accuracy and convenience of *Clinitest* (Brand) Reagent Tablets, will find the new Universal Model (No. 2155), with optional tablet refills, handier than ever.

*Clinitest*, reg. trademark

CLINITEST Urine-sugar Analysis Set
UNIVERSAL MODEL No. 2155

Contents:
- 10 CLINITEST (Brand) Reagent Tablets (Sealed in Foil)
- Instructions and Analysis Record
- Test tube and Dropper
- CLINITEST (Brand) Color Scale

may be refilled with:
- Sealed in Foil tablets (from No. 2157)
- *or* bottle of 36 tablets (No. 2107)

*Clinitest* (Brand) Urine-sugar Analysis Set (No. 2106) with the bottle of 36 tablets will continue to be available.

AMES COMPANY, INC., ELKHART, INDIANA

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# PHYSICAL MEDICINE ABSTRACTS



## BURNS FROM ELECTRICITY

G. Kenneth Lewis, M.D., Chicago, Illinois. In ANNALS OF SURGERY, 131:1:80, January 1950.

The mounting frequency of serious burns from contact with electric current stems from the constantly extended use of electricity for lighting and power, requiring transmission of electrical energy in conduits of large voltage and amperage, in the form of a continuous or alternating current.

The frequency of serious accidents from contact with electric current poses a difficult problem, both from the standpoint of severe burns with extensive tissue destruction, and extreme shock, which often results in change of personality and many times in death.

Prompt emergency treatment, of course, is imperative for the restoration of heart action in cases of extreme electric shock. Since the extent of injury from burns cannot be determined on initial examination immediately following the accident, the import of conservative care is emphasized in the first stages of treatment.

The symptoms and findings may be immediate, secondary, or delayed, and because the damage to tissue is progressive in this type of burn, prognosis should be delayed.

Two types of burns are distinguishable: that from contact and that due to arc. Lesions produced by these burns are dependent upon the path of the current, and some writers express the belief that the current spreads radially from the site of entrance and is collected again at point or points of exit, with the greatest density of the electrical field at these sites. Further, it is the consensus of opinion that in passing through the skin, the electric energy is transformed into heat, which alters the structures in the path of the current. This results in a so-called current marking of diagnostic value.

It has been pointed out in the literature that contact with 110 volts is usually fatal if the skin is moist, and the current passes through the heart in sufficient quantity to throw the ventricles into fibrillation. There is, however, a wide divergence of opinion as to whether death resulting from electric shock is caused by cardiac damage or respiratory paralysis from action on the medulla.

Five selected cases have been presented with figures, which graphically demonstrate that ultimate success or failure of repair and restoration of function following burns from electricity is dependent upon the degree of tissue destruction.

## ARTHRITIS — PLAN FOR ATTACK

Prepared by the Canadian Arthritis and Rheumatism Society, Ottawa, Ont. In THE CANADIAN MEDICAL ASSOCIATION JOURNAL, 62:1:34, January 1950.

In preparing this Plan, the Canadian Arthri-

(*Continued on page* 56)



in
hay
fever
• • •
safe
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relief

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

**Comparative studies on various antihistaminics demonstrate: NEOHETRAMINE is less toxic—extra safety more than compensates for larger doses that may be required for optimum results. For this reason, more and more physicians rely on**

# NEOHETRAMINE®

## HYDROCHLORIDE

**as their first choice in antihistaminic therapy.**

TABLETS: 25 mg., 50 mg., 100 mg.

SYRUP: 6.25 mg. per cc.; bottles of 1 pint.

**For Allergic Dermatoses**—NEOHETRAMINE CREAM, 2%; in 1 oz. tubes.

Neohetramine is the registered trademark of the Nepera Chemical Co., Inc., for its brand of thonzylamine—N, N-dimethyl-N′ p-methoxybenzyl-N′ (2-pyrimidyl) ethylenediamine.

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tis and Rheumatism Society has been deeply conscious of the magnitude of the problem which arthritis presents. It has been equally aware that a very great deal can be done, to relieve both the suffering of individuals, and the present drain on the nation's economy. The plan has been prepared as a basis for practical discussion and subsequent action by those associated with the Society, as well as for all physicians and thoughtful citizens interested in the control of rheumatic diseases.

*Importance of social and vocational rehabilitation.*—The most extensive treatment will still find many patients developing severe disabilities, and others in which disabilities cannot be wholly corrected. Yet many of them will have families to support. Thus, their medical and physical rehabilitation should be linked from the beginning with measures for social and vocational rehabilitation. Rehabilitation should start while the patient is under treatment. In many instances, the treatment provided will only make it possible for the patient to live in a better adjusted relationship with his or her disability. Rehabilitation can contribute to patient morale, and the group stimulus or therapy achieved by the concentration of patients of like disability at special treatment centers makes rehabilitation easier.

---

## EXTRA-PERITONEAL, END-TO-END SUTURE OF THE FEMORAL NERVE

Campbell Gardner, F.R.C.S. (C.), and Harold Elliott, M.D., Montreal, Que. In THE CANADIAN MEDICAL ASSOCIATION JOURNAL, 62:1:61, January 1950.

Femoral nerve lesions are rare and few have been recorded. In our series of over 500 nerve injuries, we have had only three examples of femoral nerve injury. Two were incomplete and in this third example, end-to-end suture was obtained by the method described.

*Summary*: (1) Few detailed experiences of femoral nerve injuries are recorded.

(2) Femoral nerve injuries are to be expected

(*Continued on page* 58)

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**UNTIL her physician can observe and treat her symptoms, many a woman, even today, faces the failing fires of the menopause with confusion . . .**

Physicians who are no longer satisfied with the limited action of replacement therapy alone, are electing to use a MORE COMPREHENSIVE TREATMENT for menopausal disturbances. Specifically designed for this purpose, Tablet Phen-Orivan, Dorsey provides, in addition to estrogenic substances:

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Fortunately, more and more patients each year are enjoying the therapeutic benefits of Neo-Antergan® Maleate. Because of its safe and strikingly effective action in relieving the distressing symptoms of allergy, Neo-Antergan has become a favorite antihistaminic with physicians and patients—*in every season of the year.*

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Neo-Antergan Maleate is stocked by your local pharmacy in 25 mg. and 50 mg. tablets. Complete information concerning its clinical use will be sent on request.

[1]Cooke, R. A.: *Allergy in Theory and Practice.* Philadelphia: W. B. Saunders Company, 1947, p. 186

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in lower abdominal missile wounds; and the experience in World War II has demonstrated that these wounds are not necessarily fatal.

(3) Femoral nerve suture may not be possible as early as in other peripheral nerve injuries, but recovery can be expected, even though delay is as long as two years after operation.

(4) Rehabilitation and tension (quadriceps) exercises are especially important during the recovery phase so that the patient may not become "wedded" to his brace and allow femoral muscles to develop disuse atrophy.

## THE HOSPITAL AND THE PRACTICE OF MEDICINE

Arthur C. Bachmeyer, M.D. In HOSPITAL PROGRESS, 31:2:52, February 1950.

Without physicians there can be no hospitals. Without physicians there can be no competent medical service.

The hospital was not an important institution 100 years ago. In fact, in those days it was the source of great apprehension and even dread for those whose misfortunes brought them to its doors. It was regarded largely as a terminal station in life.

While it remains true that a large majority of the conditions for which people consult their physicians can be cared for in the office, clinic, or home, the hospital is the sole agency in which all resources for the care and proper treatment of the serious illness are available. These resources are marshalled at a moment's notice by the physician's request or instruction for the benefit of his patient.

The medical profession recognizes the need for and value of hospital services. It realizes that the well organized and administered hospital makes it possible to render adequate and competent professional service. However, the best of equipment and skilled personnel do not guarantee a high quality of medical care. For this the physician — alone and collectively — through the organized staff of the hospital must be primarily responsible.

Certain other medical specialists, such as in anesthesiology, physical medicine, radiology and

(*Continued on page* 60)





*In sickness or surgery, play safer with . . .*

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Depletion of the critical water-soluble B complex and C vitamins occurs so commonly in the presence of physical pathology, as to make a presumption of nutritive impairment[2] almost axiomatic. Essential to normal cell metabolism and wound healing, these poorly-stored, readily-diffusible factors must be replenished — usually by *massive dosage* —if tissue rehabilitation[3] and return to health[4] are to be expedited. • Allbee with C 'Robins' provides this all-important "saturation dosage" in convenient capsule form. It incorporates the important B factors in 2 to 15 times daily requirements, plus 250 mg. of vitamin C — *the highest strength of ascorbic acid available today in a multi-vitamin capsule.* • Its prescription represents a sound contribution toward decisive recovery from disease, or toward pre- and post-operative nutritional support.[1]

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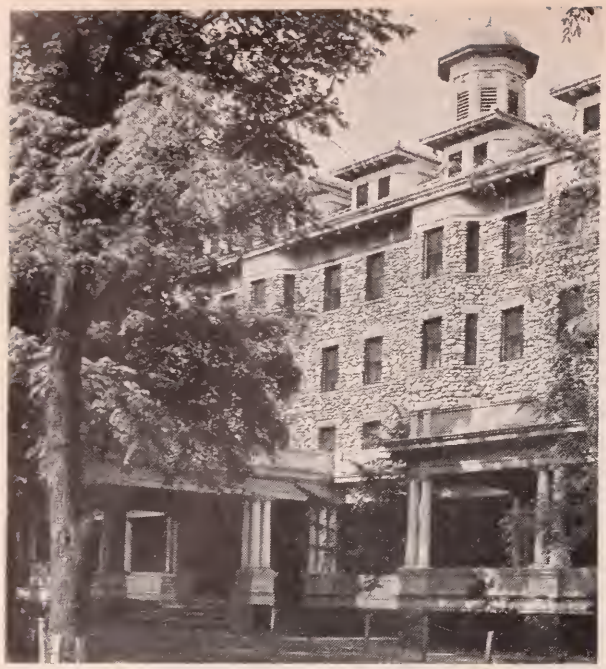
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| Nicotinamide | 50 mg. |
| Calcium pantothenate | 10 mg. |
| Ascorbic acid (C) | 250 mg. |

**REFERENCES:** 1. Coller, F. A. and DeWeese, M. S.: Preoperative and Postoperative Care, J.A.M.A., 141:641, 1949. 2. Jolliffe, N. and Smith, J. J.: Med. Clin. North America, 27:567, 1943. 3. Kruse, H. D.: Proc. Conf. Convalescent Care, New York Acad. Med., 1940. 4. Spies, T. D.: Med. Clin. North America, 27:273, 1943.

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## Physical Medicine (Continued)

pathology, in large measure, limit their professional service to the hospital. Their patients are referred to them or the services they perform are requested by their colleagues on the hospital staff. Their practice differs in form from that of most other physicians. In effect, they are given a monopoly of their services in the hospital. The financial arrangements under which they serve the institution vary widely. These financial relationships often have been the subject of sharp controversies between hospital authorities and those specialists. The basic principles enunciated some years ago by hospital and medical associations continue to be sound and fair, namely, that regardless of the particular scheme of compensation adopted, neither patient, specialist, nor hospital should be exploited. This, it would appear, is a sound principle to follow in all cases in which physicians are compensated by hospitals or related institutions.

It is important to bear in mind that nothing should be permitted to intervene between the physician and his control of his professional service. No authority, hospital or otherwise, can direct the physician's professional service. Hospitals do not and cannot practice medicine. This must remain the prerogative of the physician. Collectively, physicians can and should police their profession. They are responsible through their organized efforts for the maintenance of the highest quality of medical service that it is possible to render the public.

---

### RECONSTRUCTION OF THE DEFORMED ARTHRITIC HAND

Otto C. Kestler, M.D., New York, N. Y. In ANNALS OF SURGERY, 131:2:218, February 1950.

This is a report of a multiple surgical procedure by which a deformed arthritic hand was reconstructed into a more useful part of the extremity. Functional and cosmetic improvement was obtained and probably a foundation for preventing further increase in deformity was laid down.

A procedure is presented by which a hand seriously deformed and extremely painful due to rheumatoid arthritis was satisfactorily reconstructed.

A deformed functionally impaired thumb was

(*Continued on page 62*)

# not "food allergy"... but "casein allergy"

Inability to tolerate milk casein is one of the most frequent causes of allergy in infants. Casein allergy, as manifested by such symptoms as gastrointestinal upsets and atopic eczema, may follow the ingestion of any animal milk. In true casein allergy, all animal milks, including goat's milk, must be avoided.

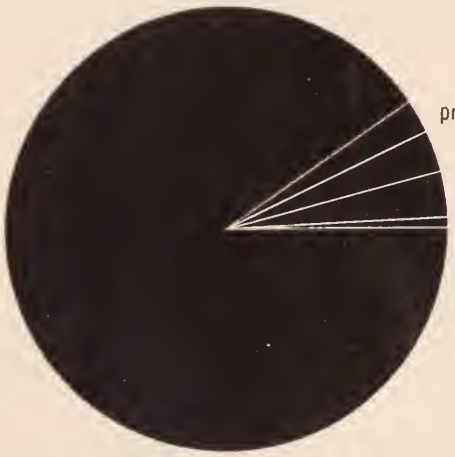
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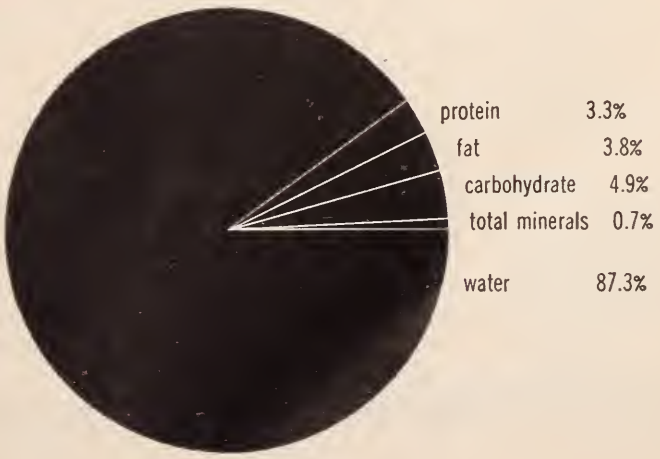
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20 calories per fl. oz.

**Average whole cow's milk**



reconstructed by complete dissection and shortening of the proximal phalanx. Fusion of the metacarpophalangeal joint was obtained and the distal phalanx could be reduced into its normal position. Useful active function could be maintained in this interphalangeal joint. The patient has been followed for 14 months.

A case is reported in which proximal shifting of the metacarpal heads was performed on the second and third metacarpal bones of the right hand. Functional and cosmetic improvement was obtained and maintained for a period of 14 months.

The merits of the two procedures — one which removed the metacarpal heads and the other which shifted the cartilaginous cups — are weighed and discussed.

## WHEN IS SURGERY NECESSARY?

M. E. Pustiz, M.D., Topeka, Kansas. In CEREBRAL PALSY REVIEW, 11:1:4, January 1950.

There is much confusion, at the present time, as to the exact status of surgery in the treatment of cerebral palsy. The reason becomes obvious when the historical development of this specialized field is considered.

Right from the very beginning, it was realized that actual surgery was but one item in the treatment, and for success, a whole routine had to be developed.

Understanding the pathology of the condition will at once indicate that there is no specific cure for it. We are therefore able to consider only what is termed palliative treatment. We are dealing with incoordinated muscle function and balance, and what we must do is to make this less incoordinated, realizing that "cure" in the ordinary sense of word will be attained only in the mild cases. Muscle education therefore forms the nucleus in the whole program of physical treatment, and always has.

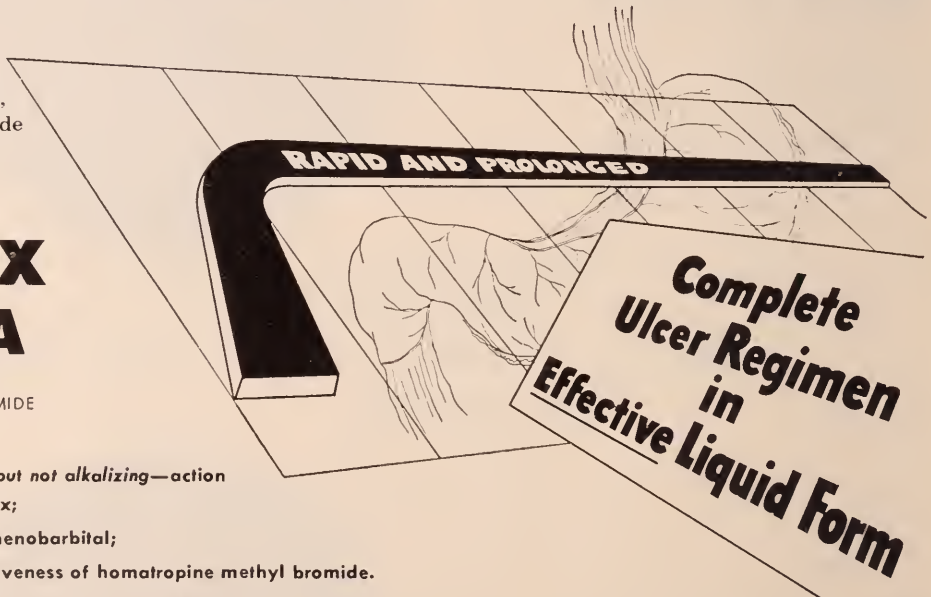
Early treatment will prevent many contractures (but not all of them). Milder deformities, of course, can always be handled with nonsurgical measures. Moderately severe deformity may take so long, even if it can be done, as to make the conservative method not worthwhile.

(*Continued on page* 64)

In palatable liquid dosage, it is now possible to provide complete and effective medical protection for the peptic ulcer patient.

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*Average dose:* one to two teaspoonfuls two hours after meals and at bedtime.

**Also:** ALZINOX MAGMA *(plain):* 0.5 Gm. (7.7 gr.) per 5 cc.—bottles of 8-oz.
ALZINOX TABLETS with Phenobarbital (1/4 gr.) and Homatropine Methyl Bromide (1/100 gr.)
ALZINOX TABLETS *(plain):* 0.5 Gm. (7.7 gr.)—bottles of 100 and 500.

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## Physical Medicine (Continued)

Severe contractures cannot be handled with physical therapy alone.

With the surgical operation, the deformity is immediately corrected, and much is done to prevent its recurrence, so that more and more time is available for advanced muscle education, balance and locomotion training, as well as the other parts of the "routine." This is not all; some of this correction is a prerequisite for advanced training, even in muscle education.

In this work, of course, it goes without saying that surgery is not done unless there is a specific reason for doing so. Mild and moderate deformity and overaction of muscle will not require surgery, if treatment is instituted early, and is adequate.

Operations may be numerous, since only a little at a time can be done. The rule is always to do too little rather than too much. In this way, there will be no harm done, and the good which is achieved at each operation will accrue. In order for all the workers, and the parents, to understand and realize the value of these surgical procedures, there will have to be much enlightenment, since as stated, the more recent trend has been to ignore this field of treatment. It is only through the cooperation of all departments, as well as the parents, and all the agencies, with the neuromuscular specialist as the pivot, that the most will be gained in the routine of treatment. The orthopedic surgeon, with many years of experience, and particular knowledge of the neuromuscular mechanism, will have much to offer to enhance and make more successful this whole routine.
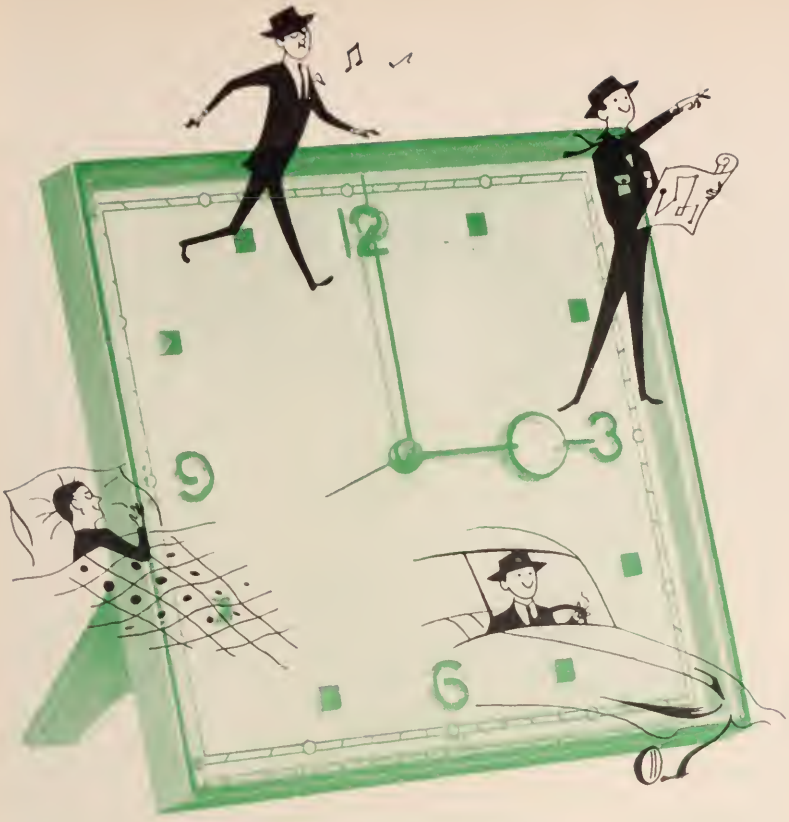
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### REPAIR OF THE COLLATERAL LIGAMENTS OF THE KNEE

B. E. McConville, M.D., F.A.C.S., Seattle, Wash. In SURGERY, GYNECOLOGY AND OBSTETRICS, 90:3:291, March 1950.

The ligaments of the knee joint are frequently injured but seldom need surgical repair. Usually conservative treatment is sufficient for complete recovery.

If the knee joint is markedly swollen the patient is placed at complete bed rest and the knee is temporarily splinted and surrounded with ice caps. If swelling has not subsided after 48 hours

(*Continued on page 66*)



For your allergic patients . . . the antihistamine that gives

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1. "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—" . . . Sheldon, J.M. Et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948)
2. "It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—" . . . MacQuiddy, E.L.: Neb. State M.J. 34:123 (1949)

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## Physical Medicine (Continued)

an aspiration of the knee joint under sterile technic is done. When the swelling has subsided an evaluation of the extent of the injury is made.

Tears of the medial and lateral ligaments are treated by a plaster cylinder extending from above the ankle to the groin. The cast is applied after the initial swelling has subsided with the knee in approximately 10 degrees of flexion and is maintained for 4 or 5 weeks. The patient is instructed in quadriceps contracture at the onset of treatment. Following the removal of the cast is an elastic bandage is applied and maintained as long as any swelling remains.

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### OUTBREAK OF POLIOMYELITIS IN CANADIAN ESKIMOS IN WINTERTIME: EPIDEMIOLOGICAL FEATURES

A. F. W. Peart. In CANADIAN JOURNAL PUBLIC HEALTH, 40:405, October 1949. Abstracted in JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 142:8:592, February 25, 1950.

The epidemic described by Peart consisted of two separate outbreaks. The first may be traced back to July 1948, at which time an Eskimo and an Indian girl developed paralytic poliomyelitis. These persons lived just north of Churchill. Early in September 1948, an Eskimo named Tutu, while returning from Churchill to Pistol Bay, visited many camps en route, in the neighborhood of Nunella and Eskimo Point. During the first week of October, 2 cases of paralytic poliomyelitis developed at Nunella and 3 at Eskimo Point, all of which were in camps visited by Tutu. One of those attacked was a missionary. Another victim at Eskimo Point was a constable who three weeks later, although paralyzed in one extremity, proceeded to Padlei. During the latter part of December, 7 paralytic cases developed at Padlei, resulting in 2 deaths. All of these cases were from camps visited by the constable. The second and more extensive outbreak of the epidemic developed at Chesterfield Inlet after the visit, on Jan. 28, 1949, of another missionary from Eskimo Point. This man resided at the hospital and visited the patients in the hospital as well as the inmates of the Industrial Home. He also visited the population in the settlement and finally returned to Eskimo Point.

(*Continued on page 68*)

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There is no doubt that this missionary had visited the poliomyelitis victims at Eskimo Point before his trip to Chesterfield. On February 14, the first case of poliomyelitis developed at Chesterfield Inlet, and within seventeen days 54 paralytic cases, with 14 deaths, had occurred. This epidemic demonstrated that poliomyelitis can appear in epidemic proportions even in extremely cold climates and suggests that the immunity of the population is probably a more important factor in the control of poliomyelitis than climatic changes.

### STUDIES ON POLIOMYELITIS IN ONTARIO: I: OBSERVATIONS ON APPARENT INFECTIOUSNESS OF ACUTE CASE

N. Silverthorne, M. P. Armstrong, F. H. Wilson and others. In CANADIAN MEDICAL ASSOCIATION JOURNAL, 61:205, September 1949. Abstracted in JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 142:8:592, February 25, 1950.

Silverthorne and associates studied from year to year the behavior of poliomyelitis in the farming area of Dufferin County, Ontario, Canada, with a population of 14,000. During the summer and autumn of 1948, the first year of study, 28 probable cases of poliomyelitis were investigated. Four of these patients were paralyzed, 8 had the nonparalytic form, and the remainder (16) had the minor type, not being confined to bed. There were 4 examples of the dromedary type of illness, and in 3 of these patients, the second period took the form of a minor illness. Laboratory confirmation of the clinical diagnosis of poliomyelitis was sought by monkey inoculation of stool extracts. Poliomyelitis virus was isolated from 7 of 16 patients whose feces were collected within three weeks of the date of onset of symptoms. One pool of 4 additional stools also proved positive for poliomyelitis virus. Two of the isolations of virus were from the stools of patients with minor illness. Serologic tests did not suggest the prevalence of infections likely to be mistaken for poliomyelitis. Careful in-

(*Continued on page 70*)


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quiries were made in every case to trace the possible source of infection. The observations suggested that the disease was spread chiefly by close contact between children. The infectious period extended from eight days before the onset of symptoms to eleven days thereafter. The child suffering from a minor illness plays a most important role in the spread of poliomyelitis. The incidence of clinical poliomyelitis in the families of 25 primary cases was investigated. None of the 52 adults became sick, and only 3 of the 55 children; this gives a secondary attack rate of 2.8 per cent in family members. In 3 instances children attended school in the infectious period immediately before the onset of symptoms. Of the total 112 contacts exposed to these cases, probably only 1 contracted clinical poliomyelitis.

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Doctors have their own friends and neighbors similar to any other citizen. They are called upon like any other neighbors to assist in emergencies. While doctors are inclined to make friends among other doctors, their friends are not limited to the medical profession, nor are their friends limited to their own patients. A great many doctors prefer to make their friends among non-patients. They find that such a relationship is more satisfactory. The friendships of the doctor and his family run the gamut of all human relations. He may have a friend that imbibes too freely, and others that are tee-totalers. Many times it is the duty of the doctor to stand by the bedside and see his best friend die. Doctors in general are generous of their time, their money, their sympathy, and their talents to their neighbors and friends. There seems to be no limit to which a general practitioner will go for a good neighbor or a good friend. Excerpt: The General Practitioner as a Citizen in His Community, J. P. Sanders, M.D., Vice-President, American Academy of Medical Association of the State of Alabama, March General Practice, Shreveport, La., The Journal of the 1950.

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The only method of controlling tuberculosis in childhood is to prevent infection. Today children are infected very largely from adults with positive sputum. It is by the control of the infective adult that, ultimately, we must seek to protect the child. F.J.W. Miller, M.D., The Lancet, August 13, 1949.

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# BOOK REVIEWS



The Genealogy Of Gynaecology: History of the Development of Gynaecology Throughout the Ages. 2000 B.C. — 1800 A. D. With Excerpts from the Many Authors who have Contributed to the Various Phases of the Subject. James V. Ricci, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Attending Gynaecologist, City Hospital, New York, etc., 494 Pages; May 17, 1950. Price $8.50 The Plakiston Company, Philadelphia and Toronto.

This is indeed an excellent source for students and those interested in gynecologic research for the author has indeed searched the literature to procure the vast amount of information it contains. Beginning with prehistoric medicine, it brings the thoughts of the various ages in regard to gynecology up to the close of the eigtheenth century.

Medical historians will find the book replete with data concerning the beliefs of those in the many periods considered in the volume, with reference to anatomy, physiology, pathology and therapy of the various gynecologic conditions. Likewise their theories concerning the impregnation of the ovum, and its development, as well as delivery at erm. Many beliefs concerning menstruation, abortion, uterine hemorrhage, and many other gynecologic and obstetrical problems are given in the book.

Part one refers to gynecology in the prehistoric period. Part two, the ancient epoch, giving information on gynecologic beliefs and practice in Egypt, Babylon-Assyria, the Hindus and as related in the Bible. Part three, the Classic Age, beginning with pre-Hippocratic concepts and coming to the Galen era. Then in succeding chapters, the Byzantine Period, The Arabic Era, The Mediaeval Epoch, and the Transitional Period from the 15th through the 18th centuries. Many references appear in the volume, and there is a very extensive bibliographic reference, showing the amount of research work on the part of the author to make this interesting book possible.

Specialists and those interested in gynecologic research will find much of interest in the book, likewise it will be of much value to students, and those interested in history of medicine and the development of medical practice.

---

Diabetes And Its Treatment. By Joseph H. Barach, M.D., F.A.C.P. Associate Professor Medicine, University of Pittsburg; Senior Medical Staff, Presbyterian Hospital; Medical Director, Outpatient Department of the Medical Center Hospitals; School of Medicine, University of Pittsburg. President, American Diabetes Association (1944-6). Chairman, Metabolism and Endocrinology Study Section, Research Grants Division, U. S. Public Health Service (1946-51). 326 Pages. Oxford University Press, New York. $10.00.

With the number of elderly people in the United States gradually increasing due to medical progress under our free enterprise system, degenerative diseases such as diabetes are becoming more important. This new book represents a definite addition to the field of diabetic literature. It is complete, well written and the charts are illustrative. The last third of the book is made up of a system of diet including a complete range of diets so that the physician may decrease the book-keeping which forms so great a part of the treatment of diabetes. The book is written for the practitioner rather than the research scientist. Recommended.

J. C. S.

(*Continued on page 74*)



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## BOOK REVIEWS (Continued)

INDUSTRIAL TOXICOLOGY. By Lawrence T. Fairhall. Scientist Director, Public Health Service, Federal Security Agency, Chief, Industrial Hygiene Laboratory, Industrial Hygiene Division. 483 Pages. Williams & Wilkins, Baltimore. 1949. $6.00.

Industrial medicine is becoming increasingly important and this book represents a welcome addition to works in this field. The discussion of the various substances used in industry which may be toxic to man is broken down into inorganic carbon compounds and under these listings substances are listed alphabetically. The extent of production and use of the materials is indicated to give an idea of exposure.

Recommended for those interested in industrial medicine.

---

WORLD SURGERY, 1950. Stephen A. Zieman, M.D., 177 pages; 53 illustrations. Price $6.00. J. B. Lippincott Company, Philadelphia.

The author, who is abstract and new editor of the Journal of the International College of Surgeons, has given a survey of the world literature in surgery, which he has chosen from the many surgical journals of the entire world. It was his desire in preparing the book to show surgeons in this country what is being done elsewhere and give the prevailing ideas, methods of reasoning and practice of the many surgeons in 1950.

The author, a surgeon himself, selects the unusual from the voluminous surgical literature, giving the approach of the writers, then his own comments on many of the procedures described. He has arranged the table of contents according to the amount of literature available on the many surgical subjects, and it is not based entirely on anatomical grounds. The first section deals with gastrointestinal surgery, and many subjects are covered in this portion of the book. Although the individual articles are short and to the point, those desiring further information have available the bibliographic references so they may easily find the original article commented upon, for further information as may be desired.

The subjects of cardiovascular-respiratory surgery gynecology, obstetrics, orthopedics, genito-urinary surgery, neurosurgery, ophthalmology and otolaryngology, and surgery of the head and neck are presented in individual sections. Under miscellaneous, the subjects of anesthesiology, radiology, pre and postoperative care, blood substitutes and antibiotics in their surgical uses, are carefully presented.

The index of authors and index of subjects will be of much interest to the surgeon, and show the vast amount of surgical literature which has been carefully

(*Continued on page* 76)

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1. HANSEL, F.: Ann. Allergy *6:* 155 (Mar.) 1949.
2. FRIEDMAN, A. and BRENNER, C.: Am. Pract. *2:* 467 (Mar.) 1948.
3. HORTON, B., RYAN, R., and REYNOLDS, J.: Proc. Staff. Meet., Mayo Clin. *23:* 105 (Mar. 3) 1948.
   CHARLES, C.: Postgrad. Med. *7:* 33 (Jan.) 1950.
   MOENCH, L.: Dis. Nerv. System *10:* 143 (May) 1949.
   FRIEDMAN, L.: J.M.A. Ala. *19:* 137 (Nov.) 1949.
   RYAN, R.: J. Missouri M.A. *47:* 107 (Feb.) 1950.

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read by the author to make this book possible. The long list of Journals from which the abstracts have been taken is likewise interesting, and they are published in nearly every civilized country of the entire world.

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---

THE MERCK MANUAL of Diagnosis and Therapy. A Source of Ready Reference for the Physician. Published by Merck and Company, Inc., Rahway, N. J. Eighth Edition. Price: Regular edition $4.50; Thumb Index Edition $5.50.

This eighth edition of an ever popular reference book on diagnosis and therapy nearly 1600 pages, but as it is printed on thin paper, is not at all unwieldly and is approximately the same size as previous editions. The book contains 82 more chapters than the last edition and it well covers the modern day field of medicine and its branches.

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---

ESSENTIALS OF PATHOLOGY. By Lawrence W. Smith, M.D., F.C.A.P., formerly Professor of Pathology, Temple University School of Medicine, Associate Professor of Pathology, Cornell University Medical School, and Assistant Professor of Pathology, Harvard College. Corresponding member of the Royal Flemish Medical Academy of Belgium; and Edwin S. Gault, M.D., F.C.A.P., Associate Professor of Pathology and Bacteriology, Temple University School of Medicine. 3rd Ed. 763 Pages. $12.00 Blakiston, Philadelphia.

This is a practical book for the student of Pathology attempting to give him a thorough grounding in the principles of pathology. The case history method is used extensively. Errors and omissions have been corrected and additional material has been added without increasing the size of the book. A valuable aid for the student.

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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

LECTURES ON MEDICINE TO NURSES. By A. E. Clark-Kennedy, M.D., F.R.C.P., Fellow of Corpus Christi College, Cambridge, Physician to the London Hospital and Dean of the Medical School. With a foreward by Miss Clare Alexander, Matron of the London Hospital. The Williams and Wilkins Company, Baltimore, 1950. 288 pages. $3.50.

THE CYTOLOGY AND LIFE-HISTORY OF BACTERIA. By K. A. Bisset, Ph. D., Lecturer in Bacteriology, University of Birmingham. The Williams & Wilkins Company, Baltimore, 1950. 136 pages. $3.50.

TYPES OF DIABETES MELLITUS AND THEIR TREATMENT: By Arthur R. Colwell, M.D., Associate Professor of Medicine and Director of Medical Specialty Training Northwestern University Medical School, Attending Physician, Evanston Hospital, Consulting Physician, Wesley Memorial Hospital, Municipal Tuberculosis Sanitarium, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. 97 pages. $2.25.

MALIGNANT DISEASE AND ITS TREATMENT BY RADIUM: By Sir Stanford Cade, K.B.E., C.B., F.R.C.S.,


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M.R.C.P., with a foreword by Sir Ernest Rock Carling, R.F.C.P., F.R.C.S., F.F.R. Volume 3, Second Edition. The Williams and Wilkins Company, Baltimore, 1950, 446 pages. $12.50.

THE LIVER, PORTA MALORUM (The Gateway to Disease). By Kasper Blond, M.D. (Vienna), L.R.C.P., L.R.C.S. (Ed.), L.R.F.P.S. (Glas.) and David Haler, M.B., D.C.P. (Lond.). The Williams and Wilkins Company, Baltimore, 1950. 268 pages. Price $5.00.

PRINCIPLES OF PUBLIC HEALTH ADMINISTRATION. By John J. Hanlon, M.S., M.D., M.P.H., Associate Professor of Public Health Practice, School of Public Health, University of Michigan, and Chief Medical Officer and Associate Chief of Party, Bolivia, The Institute of Inter-American Affairs. The C. V. Mosby Company, St. Louis, 1950. 506 pages. 48 illustrations. $6.00.

PYE'S SURGICAL HANDICRAFT. A Manual of Surgical Manipulations, Minor Surgery, and Other Matters Connected with the Work of Surgical Dressers, House Surgeons and Practitioners. Edited by Hamilton Bailey, F.R.C.S. Eng. Sixteenth Edition, Fully revised with 830 illustrations. 724 pages. The Williams and Wilkins Company, Baltimore, 1950. $6.00.

WILLIAM WITHERING OF BIRMINGHAM, M.D., F.R.S., F.L.S., By T. Whitmore Peck, M.P.S., K. Douglas Wilkinson, O.B.E., M.D. (Birm), F.R.C.P. (Lond.), The Williams and Wilkins Company, Baltimore: 1950. 239 pages. $4.50.

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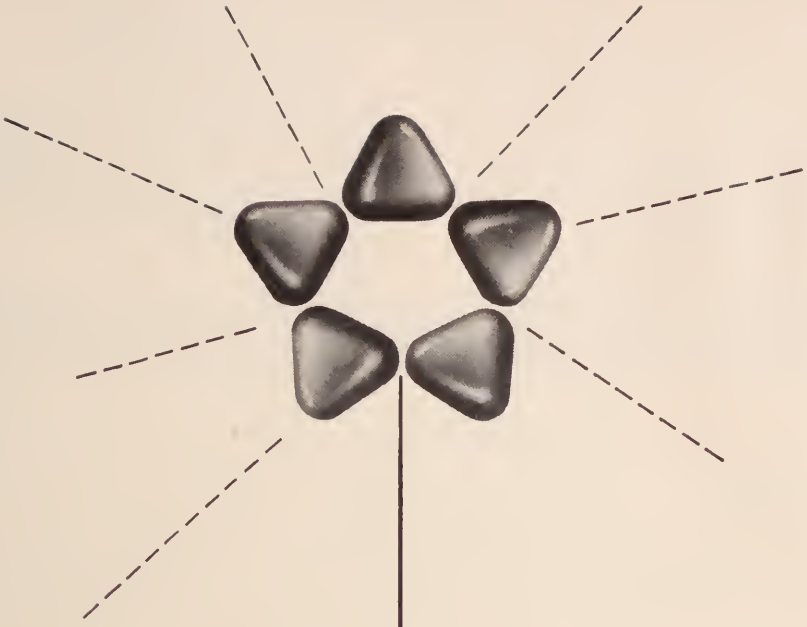
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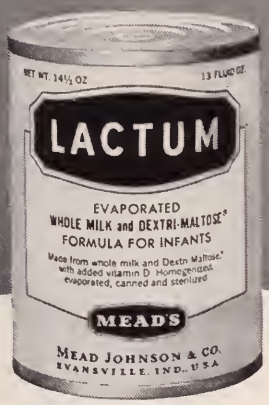
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# The ILLINOIS Medical Journal

VOL. 98 NO. 4

October, 1950

## Prevention of Respiratory Infections in Children

## Experiences with Neoplastic Diseases of the Thyroid Gland

## Laboratory Diagnosis of Virus Infections

(See page 5 for Table of Contents)

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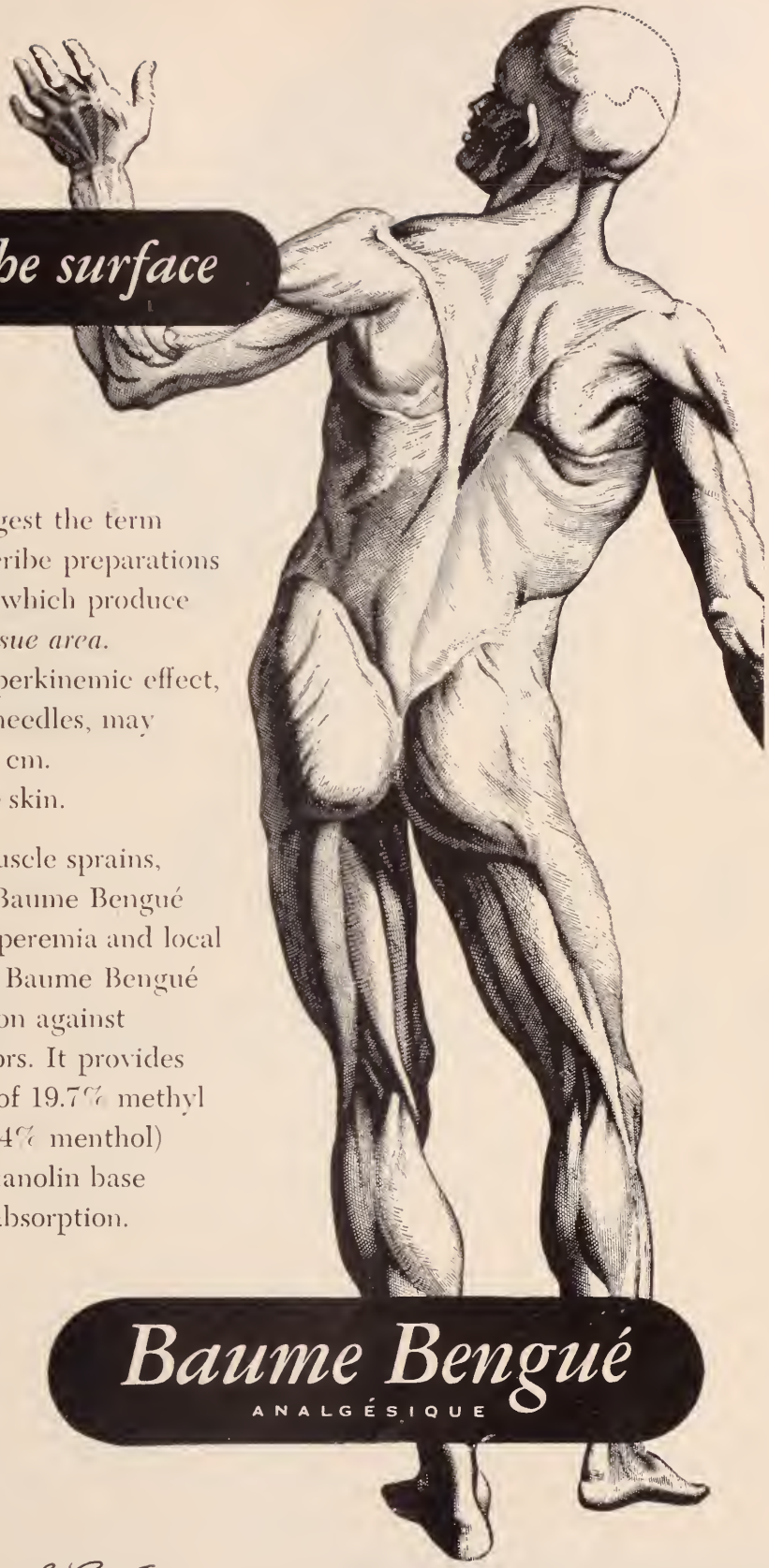
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*1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.*

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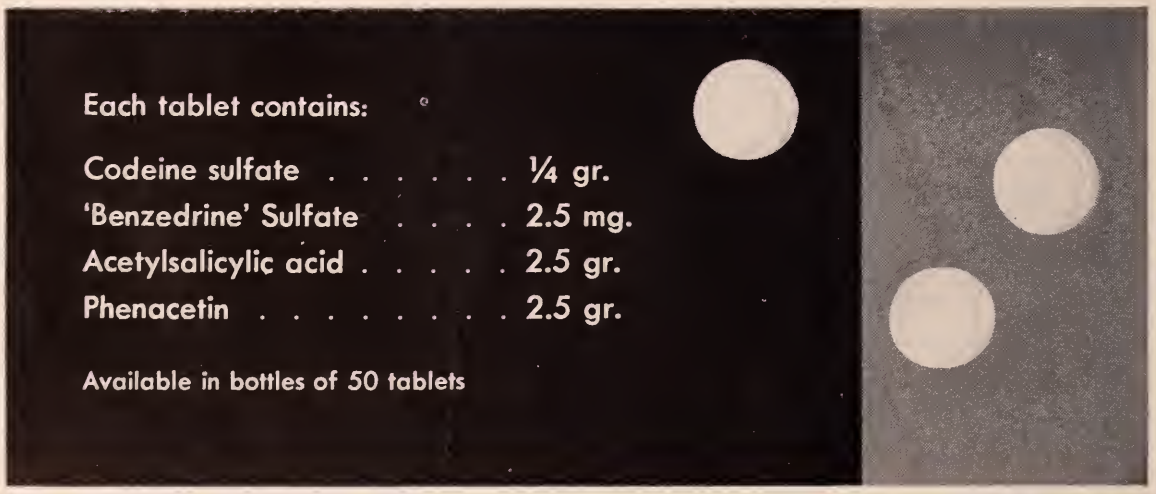
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1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obst. & Gynec. *57*:541 (1949).
2. Chesley, R. R., and Annitto, J. E.: Bull. Margaret Hague Mat. Hosp. *1*:68 (1948).
3. Neary, E. R.: Am. J. M. Sc. *212*:76 (1946).
4. Kelly, H. T.: Pennsylvania M. J. *51*:999 (1948).


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(1.) Felch, W. C.: New York Med. *5*:16 (Oct. 20) 1949. (2.) Leinwand, I., and Moore, D. H.: Am. Heart J. *38*:467 (Sept.) 1940. (3.) Felch, W. C., and Dotti, L. B.: Proc. Soc. Exper. Biol. & Med. *72*:376 (Nov.) 1949.

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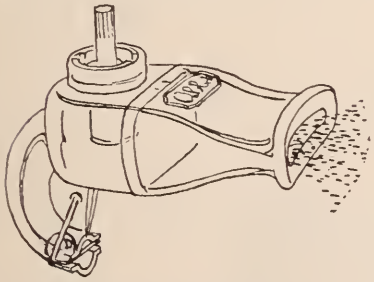
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** Brand of sulfisoxazole (3,4-dimethyl-5-sulfanilamido-isoxazole)*

**'Roche'**



Stops wracking cough...



but keeps the cough reflex

MERCODOL provides prompt, selective relief that doesn't interfere with the cough reflex needed to keep throat passages and bronchioles clear.

This complete, pleasant-tasting prescription contains a *selective* cough-controlling narcotic[1] that doesn't impair the beneficial cough reflex . . . an effective bronchodilator[2] to relax plugged bronchioles . . . an expectorant[3] to liquefy secretions. Remarkably free from nausea, constipation, retention of sputum, and cardiovascular or nervous stimulation.

# MERCODOL®

THE ANTITUSSIVE SYRUP THAT CONTROLS COUGH—*KEEPS* THE COUGH REFLEX

An exempt narcotic

**MERCODOL** with **DECAPRYN®**
for the cough with a specific allergic basis.

Merrell
1828
CINCINNATI • U.S.A.

Each 30 cc. contains:

| | | |
|---|---|---|
| [1] | Mercodinone® | 10.0 mg. |
| [2] | Nethamine® Hydrochloride | 0.1 Gm. |
| [3] | Sodium Citrate | 1.2 Gm. |

*One of a series of reports on*

# Cortone*

TRADE MARK

## Key to a New Era in Medical Science

### THE CLINICAL RESPONSE In RHEUMATOID ARTHRITIS And Its VARIANTS

THE usual pattern of response to CORTONE begins with diminution in subjective stiffness, commonly within 24 to 48 hours, but sometimes within 6 hours after the initial dose. In many cases this symptom is significantly or completely relieved within a few days. Next, articular tenderness and pain on motion decrease. Finally, swellings of the joints diminish, sometimes fairly rapidly and completely, but occasionally more slowly and incompletely.

In many patients, mild soft-tissue deformities of the knees or elbows have disappeared within 7 to 10 days. An increase in muscle strength has been reported. The extent of return to normal has been limited, as must be expected, by the degree of permanent pathologic change present.

Appetite usually improves rapidly, and many patients have described a loss of the feeling of malaise associated with the disease and have experienced a sense of well-being, occasionally within several hours after initial administration of the drug.

When treatment with CORTONE is discontinued, signs and symptoms may begin to reappear within 24 to 48 hours, becoming gradually worse during the following 2 to 4 weeks. The degree of relapse varies, and is apparently unrelated to the duration of treatment. In some patients, however, the greater part of the remission has persisted for as long as several weeks or months. If CORTONE is re-administered when manifestations of the disease return, prompt remission is again induced.

*Among the conditions in which Cortone has produced striking clinical improvement are:*

**RHEUMATOID ARTHRITIS** and Related Rheumatic Diseases

**ACUTE RHEUMATIC FEVER**

**BRONCHIAL ASTHMA**

**EYE DISEASES,** Including Nonspecific Iritis, Iridocyclitis, Uveitis, and Sympathetic Ophthalmia

**SKIN DISORDERS,** Notably Pemphigus, Angioneurotic Edema, Atopic Dermatitis, and Exfoliative Dermatitis, Including Cases Secondary to Drug Reactions.

*CORTONE is available for use in hospitals having facilities for required laboratory studies, and also for use in nonhospitalized cases following initial therapy in such hospitals. These hospitals can supply physicians' requirements for Cortone.*

MERCK & CO., INC.
*Manufacturing Chemists*
RAHWAY, NEW JERSEY

*Cortone
TRADE-MARK

ACETATE
**(CORTISONE Acetate Merck)**
**(11-Dehydro-17-hydroxycorticosterone-21-Acetate)**

*Trade-mark of Merck & Co., Inc. for its brand of cortisone.

'B'

*major*

"Beminal" offers major 'B' therapy with a quintet of distinctive combinations that simplify selection of appropriate treatment for each patient.

1. "***Beminal***" Forte with Vitamin C (Capsules No. 817) is recommended whenever oral administration of massive doses of B factors and vitamin C is desirable.

Each capsule contains:

| | |
|---|---|
| Thiamine HCl ($B_1$) | 25.0 mg. |
| Riboflavin ($B_2$) | 12.5 mg. |
| Nicotinamide | 100.0 mg. |
| Pyridoxine HCl ($B_6$) | 1.0 mg. |
| Calc. pantothenate | 10.0 mg. |
| Vitamin C (ascorbic acid) | 100.0 mg. |

*Dosage:* One to three capsules daily or as directed by the physician.

The other members of the "Beminal" family are:

2. "***Beminal***" fortified with Iron and Liver, Capsules No. 816.

3. "***Beminal***" fortified with Iron, Liver, and Folic Acid, Capsules No. 821.

4. "***Beminal***" Forte Injectable (Dried) No. 495.

5. "***Beminal***" Tablets No. 815.

Ayerst, McKenna & Harrison Limited

22 East 40th Street, New York 16, N. Y.



in convalescence . . .

# Theptine

makes a

big difference



In convalescence a return to normal health is frequently retarded by two barriers: mental depression and nutritional depletion. In such cases 'Theptine' has proved to be an ideal preparation to help speed recovery.

'Theptine' supplies, in a light and pleasing elixir, the unique antidepressant action of 'Dexedrine' Sulfate *plus* the nutritional action of thiamine, niacin and riboflavin. 'Theptine' improves both the mental and physical tone of the patient . . . helps speed his return to normal life and living. *Smith, Kline & French Laboratories, Philadelphia*

Each 5 cc. (1 teaspoonful) contains:

| | |
|---|---|
| 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.) | 2.5 mg. |
| Thiamine hydrochloride | 5.0 mg. |
| Riboflavin | 0.45 mg. |
| Niacin | 6.7 mg. |

**Theptine**

Available in 12 fl. oz. bottles.

'Dexedrine' plus essential B vitamins

**an antidepressant and nutrient elixir**

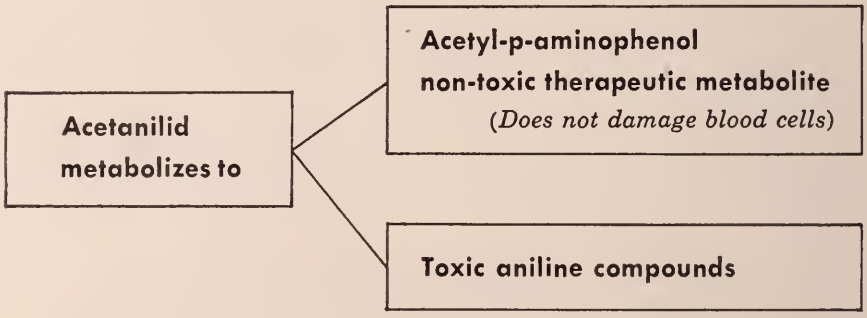
'Theptine' & 'Dexedrine' are S.K.F. Trademarks

*Now offered to the medical profession for the first time*

# *A new analgesic compound containing acetyl-p-aminophenol*

*. . . the non-toxic therapeutic metabolite of acetanilid*

Long known as one of the most potent, rapid-acting analgesics, acetanilid has now been found to have a non-toxic therapeutic factor—*acetyl-p-aminophenol.* Studies at the Yale Laboratory of Applied Physiology and New York University School of Medicine show that *acetyl-p-aminophenol* has the high analgesic potency of acetanilid, without its toxicity. Unlike acetanilid and acetophenetidin compounds, *acetyl-p-aminophenol* does not damage blood cells, is safe even for chronic pain.




## TRIGESIC

Squibb *acetyl-p-aminophenol,* Aspirin and Caffeine Tablets

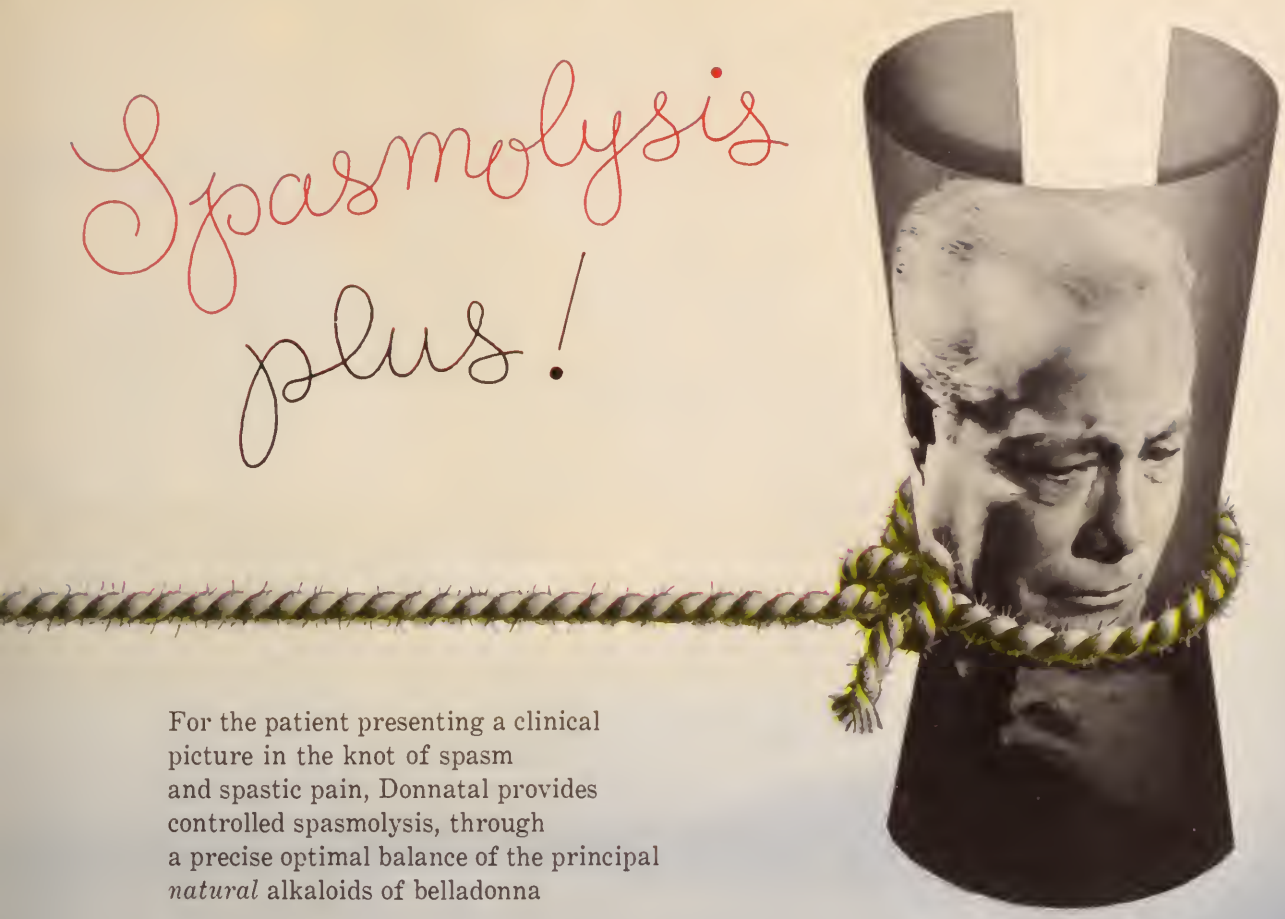
Trigesic offers all the advantages of acetanilid . . . none of the disadvantages . . . plus the benefits of aspirin and caffeine

Each tablet contains 0.125 Gm. *acetyl-p-aminophenol;* 0.23 Gm. aspirin and 0.03 Gm. caffeine. *Bottles of 36, 100 and 1,000.* Also available as TRIGESIC WITH CODEINE, containing, in addition, 16 mg. codeine phosphate. *Bottles of 100.*

**SQUIBB**

"TRIGESIC" IS A TRADEMARK OF E. R. SQUIBB & SONS

# Spasmolysis plus!



For the patient presenting a clinical picture in the knot of spasm and spastic pain, Donnatal provides controlled spasmolysis, through a precise optimal balance of the principal *natural* alkaloids of belladonna

plus central and peripheral sedation plus freedom from toxic reaction plus choice of alternate dosage forms

plus broad therapeutic applicability in spasm of the gastro-intestinal, biliary, urogenital, respiratory and central nervous systems

plus outstanding economy




**Each tablet or capsule, and each 5 cc. of elixir contains:**

| | |
|---|---|
| Hyoscyamine Sulfate | 0.1037 mg. |
| Atropine Sulfate | 0.0194 mg. |
| Hyoscine Hydrobromide | 0.0065 mg. |
| Phenobarbital (¼ gr.) | 16.2 mg. |

# donnatal®

## elixir, tablets, capsules

for effective relief of visceral spasm . . . Donnatal Elixir acceptable to *all* ages as spasmolytic alone, or as a therapeutic vehicle for adjuvant medication.

**A. H. Robins Co., Inc. · Richmond 20, Virginia**

Robins

Ethical Pharmaceuticals of Merit since 1878

# now... digestant enzymes released in relay by the peptomatic* tablet

*A coined word to describe the unique mechanical action of the Entozyme Tablet, whereby:




1 pepsin is released only in the stomach, and

2 pancreatin and bile salts are released only in the small intestine.

The multiform aid required in digestional dysfunction or imbalance may now be administered in a single tablet—Robins' Entozyme—which (by unique Peptomatic* action) releases pepsin, pancreatin and bile salts individually at the gastroenteric levels of respective optimal activity. Entozyme has proven particularly efficacious[1,2] in chronic cholecystitis, post-cholecystectomy syndrome, infectious hepatitis, pancreatitis, chronic dyspepsia, and peptic ulcer. It is also especially useful in nausea, anorexia, belching, flatulence and pyrosis.

**formula:**

Each specially constructed tablet contains pancreatin, U.S.P., 300 mg.; pepsin, N.F., 250 mg.; bile salts, 150 mg.

**references**

1. McGavack, T.H., and Klotz, S.D.: Bull. Flower Fifth Ave. Hosp., 9:61, 1946. 2. Weissberg, J., et al.: Am. J. Digest Dis., 15:332, 1948.

Robins

**entozyme®**

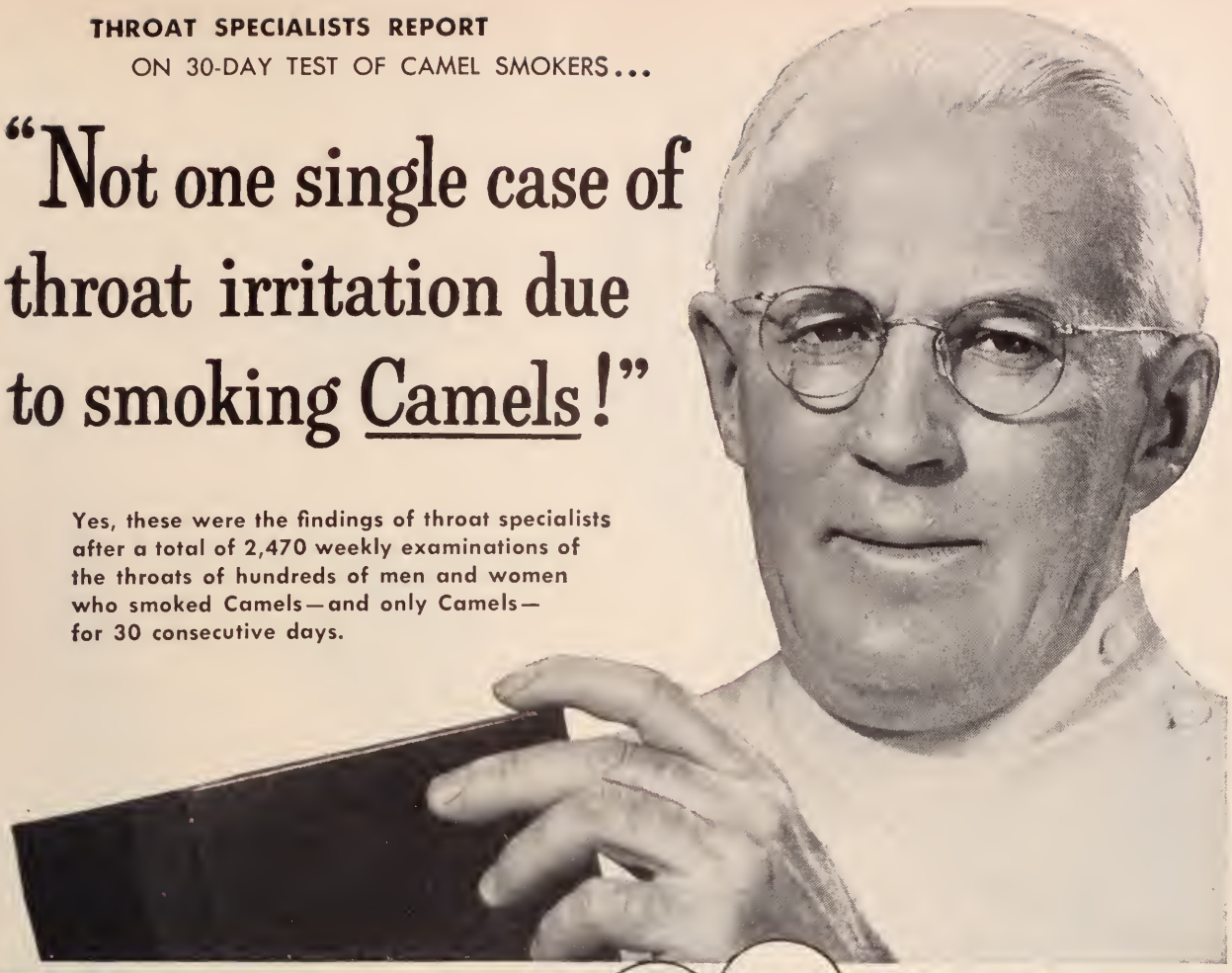
The multi-enzyme digestant with unique Peptomatic Action!

A. H. Robins Co., Inc. · Richmond 20, Virginia

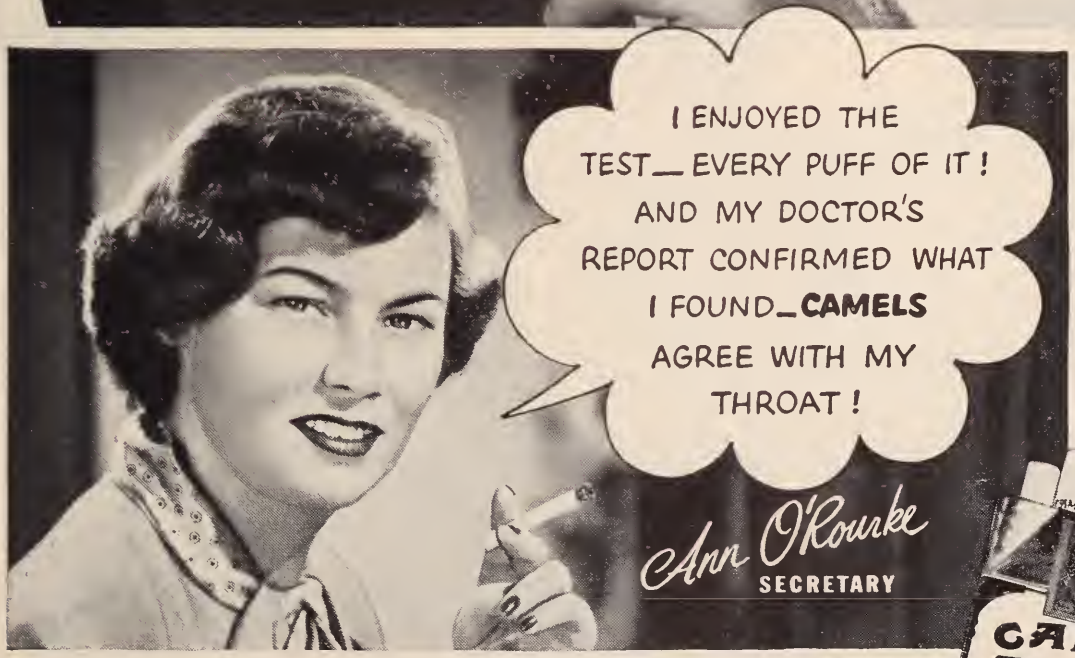
Ethical Pharmaceuticals of Merit since 1878

**THROAT SPECIALISTS REPORT**
ON 30-DAY TEST OF CAMEL SMOKERS...

# "Not one single case of throat irritation due to smoking Camels!"



Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.




R. J. Reynolds Tobacco Co., Winston-Salem, N. C.



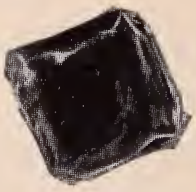

ACCORDING TO A NATIONWIDE SURVEY:

# More Doctors Smoke Camels

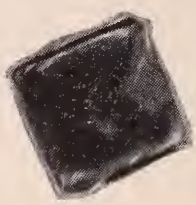
## THAN ANY OTHER CIGARETTE

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel.









• 20,000 units penicillin in a delicious hard candy

## High Oral Penicillin Levels Lasting One-half Hour

# PONDETS*

PENICILLIN TROCHES



Potent local therapy and prophylaxis of oral infections caused by penicillin-sensitive organisms.

Taste so good that your patients—young and old—will gladly follow the prescribed dosage regimen.

Wyeth®

WYETH INCORPORATED
Philadelphia 3, Pa.

*Trade-mark

*for your patients with*

**NUTRITIONAL ANEMIA**



**ANEMIA OF BLOOD LOSSES**



**ANEMIA OF THE AGED**



**ANEMIA OF HYPERMENORRHEA**



**ANEMIA OF PREGNANCY AND LACTATION**



**GENERAL DEBILITY AND DURING CONVALESCENCE**



*prescribe*

# CYTORA

**BLOOD BUILDER AND NUTRITIONAL SUPPLEMENT**

ORGANON

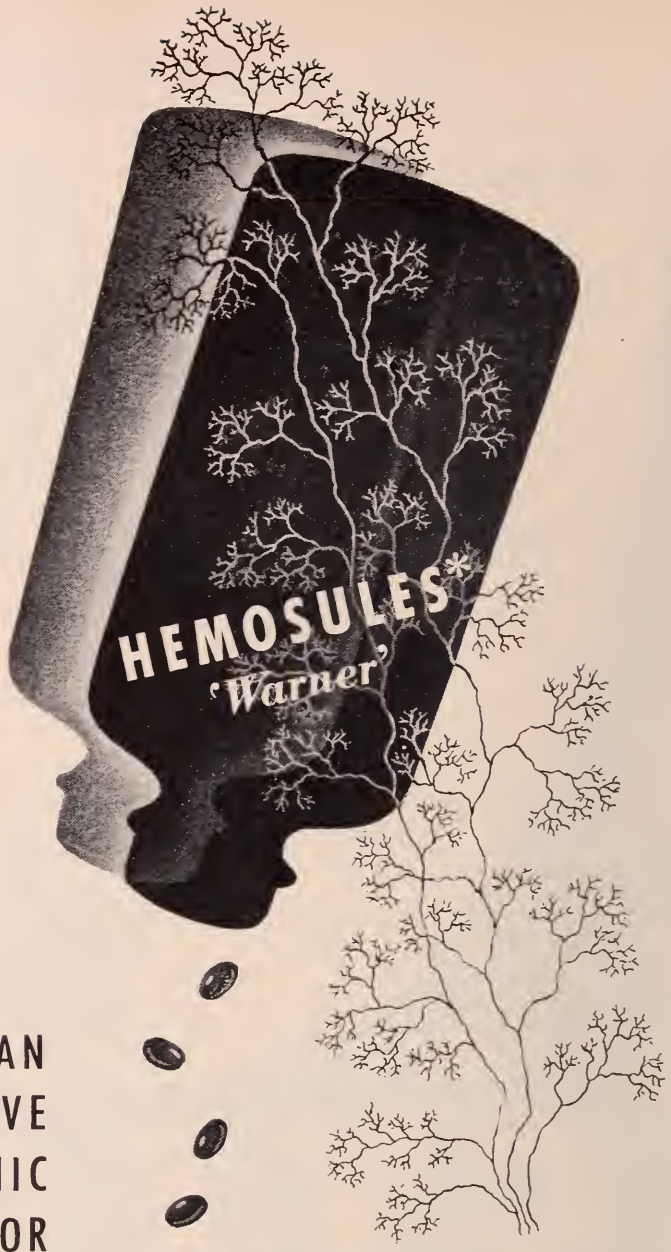
Cytora, in the recommended daily dose of 6 tablets, provides: exsiccated ferrous sulfate, 600 mg; folic acid, 4.5 mg; liver concentrate, 900 mg; vitamin C, 150 mg; vitamin $B_1$, 6 mg; vitamin $B_2$, 6 mg; vitamin $B_6$, 3.0 mg; niacinamide, 30 mg; calcium pantothenate, 6 mg; and other factors naturally present in liver concentrate. Cytora is available in bottles of 100, 250, and 1000 tablets.

ORGANON INC. • ORANGE, N. J.

Trade Mark Cytora

# THE EFFECTIVE HEMATINIC FOR THE ANEMIAS OF . . .

nutritional inadequacies
pre- and post-natal demands
dietary restrictions
gynecological disorders
acute or chronic blood losses
pre- and post-surgical conditions
acute or chronic infections
debilitating diseases
"run-down" or lowered resistance states




## AN EFFECTIVE HEMATINIC FOR ALL HYPOCHROMIC ANEMIAS..... HEMOSULES* 'Warner'

The recommended daily dose of 6 HEMOSULES* provides...

| | |
|---|---|
| 15 grains of dried Ferrous Sulfate, U.S.P., equivalent to 285 mg. of assimilable iron or 28 x M.D.R.† | |
| Thiamin hydrachloride (Vitamin $B_1$) | 6.0 mg. (6 x M.D.R.†) |
| Riboflavin (Vitamin $B_2$) | 6.0 mg. (3 x M.D.R.†) |
| Ascorbic acid (Vitomin C) | 90.0 mg. (3 x M.D.R.†) |
| Niacinomide** | 24.0 mg. |
| Pyridoxine hydrochloride (Vitamin $B_6$)*** | 3.0 mg. |
| d-Panthenol (equiv. to 3.0 mg. Pantothenic acid)*** | 2.82 mg. |
| Folic acid*** | 1.2 mg. |
| Liver Fraction 2 (15 grs.) | 972.0 mg. |




*Trade Mark

†Minimum daily adult requirement.

**The minimum daily requirement for niacinomide has not been established.

***The need for pyridoxine hydrochloride, pantothenic acid and folic acid in human nutrition has not been established.

WILLIAM R. WARNER
Division of Warner-Hudnut, Inc.
New York • Los Angeles • St. Louis

# *natural choice*

# DESICOL®

**desiccated whole bile**

# *for bile therapy*




DESICOL medication is utilized in treatment of intestinal indigestion and putrefaction, of constipation, and of other conditions in which bile deficiency may be a factor.

DESICOL Kapseals® are a natural choice in management of disorders of the liver, gallbladder and biliary passages.

DESICOL, Kapseals, containing fresh whole bile with only the water removed, supply all the original bile factors. Action closely resembles that of natural whole bile in clinical effect.

Therefore, DESICOL Kapseals have a four-fold action:

- increase formation of liver bile (cholepoietic effect)
- increase bile volume (choleretic effect)
- stimulate emptying of the gallbladder (cholagogic effect)
- compensate for deficiencies of bile in the digestive process.

Kapseals DESICOL are supplied in bottles of 100 and 1000.

**PARKE, DAVIS & COMPANY**

MEDICAMENTA VERA · P CO.




# Drop-cillin

**50,000 UNITS*** in a dropperful

9 cc. bottle contains 600,000 units.

# Dram-cillin

**100,000 UNITS*** in a teaspoonful

60 cc. bottle contains 1,200,000 units.

Both with a delicious vanilla flavor.

*buffered penicillin G potassium

*White Laboratories, Inc.,*
*Pharmaceutical Manufacturers, Newark 7, N. J.*

# no excitation . . .

# no wakefulness

Because the vasoconstrictor of Benzedrex Inhaler is a derivative of cyclohexane—not a derivative of benzene as is ephedrine—it produces almost no central nervous stimulation.

Benzedrex Inhaler may therefore be freely used even by those individuals in whom such ephedrine-like effects as insomnia, restlessness, or nervousness are frequently encountered.

Benzedrex Inhaler provides more rapid shrinkage, more complete shrinkage, and more prolonged shrinkage. Its clean, medicinal odor assures your patients' cooperation between their treatments in your office.

*Smith, Kline & French Laboratories, Philadelphia*

# Benzedrex Inhaler

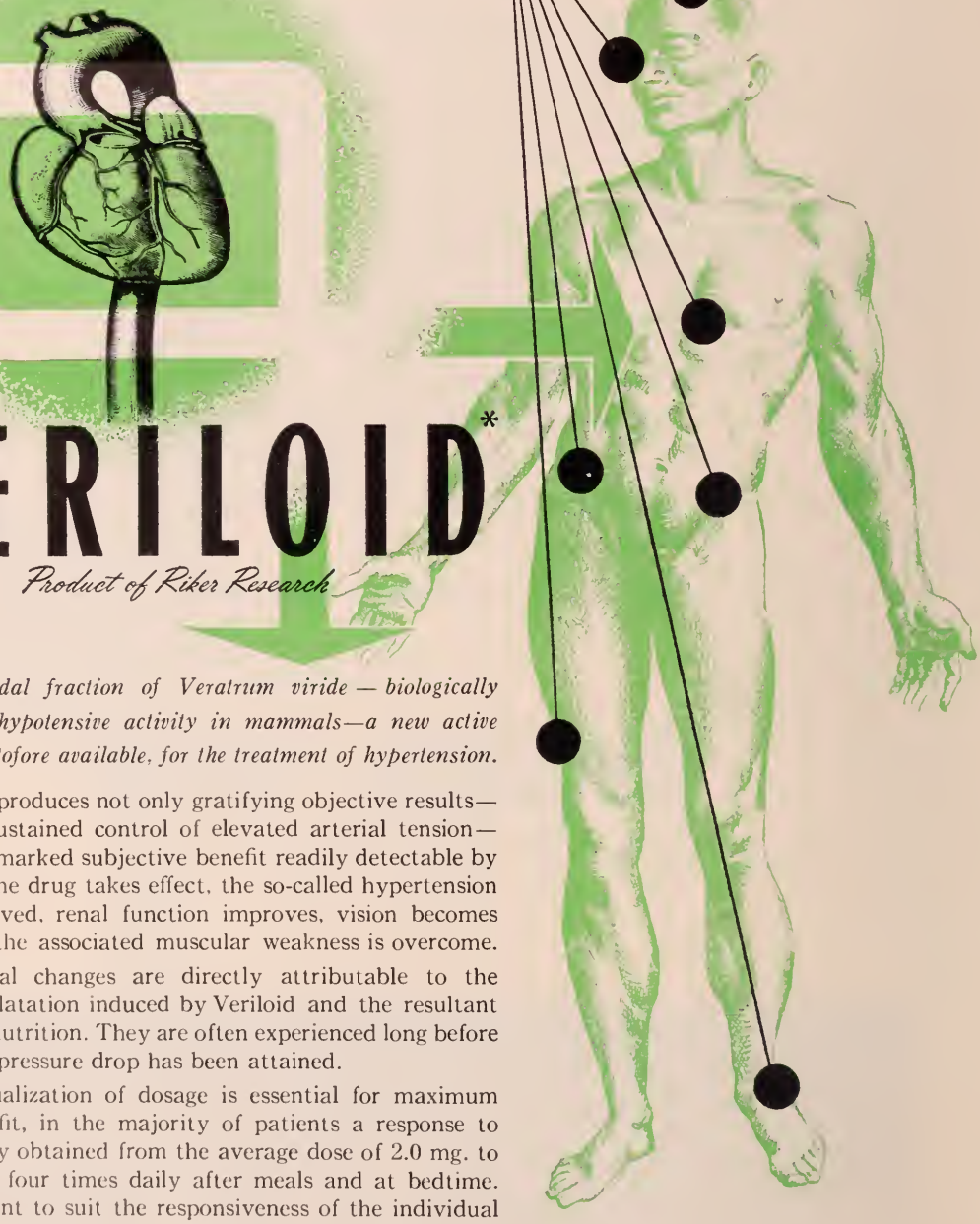
***the best inhaler ever developed***

'Benzedrex' T.M. Reg. U.S. Pat. Off.



# *The Entire Hypertension Syndrome*

## RESPONDS



# VERILOID*

*Product of Riker Research*

*A potent alkaloidal fraction of Veratrum viride — biologically standardized for hypotensive activity in mammals—a new active principle not heretofore available, for the treatment of hypertension.*

Veriloid therapy produces not only gratifying objective results—significant and sustained control of elevated arterial tension—but also leads to marked subjective benefit readily detectable by the patient. As the drug takes effect, the so-called hypertension headache is relieved, renal function improves, vision becomes more clear, and the associated muscular weakness is overcome.

These beneficial changes are directly attributable to the peripheral vasodilatation induced by Veriloid and the resultant improved tissue nutrition. They are often experienced long before maximum blood pressure drop has been attained.

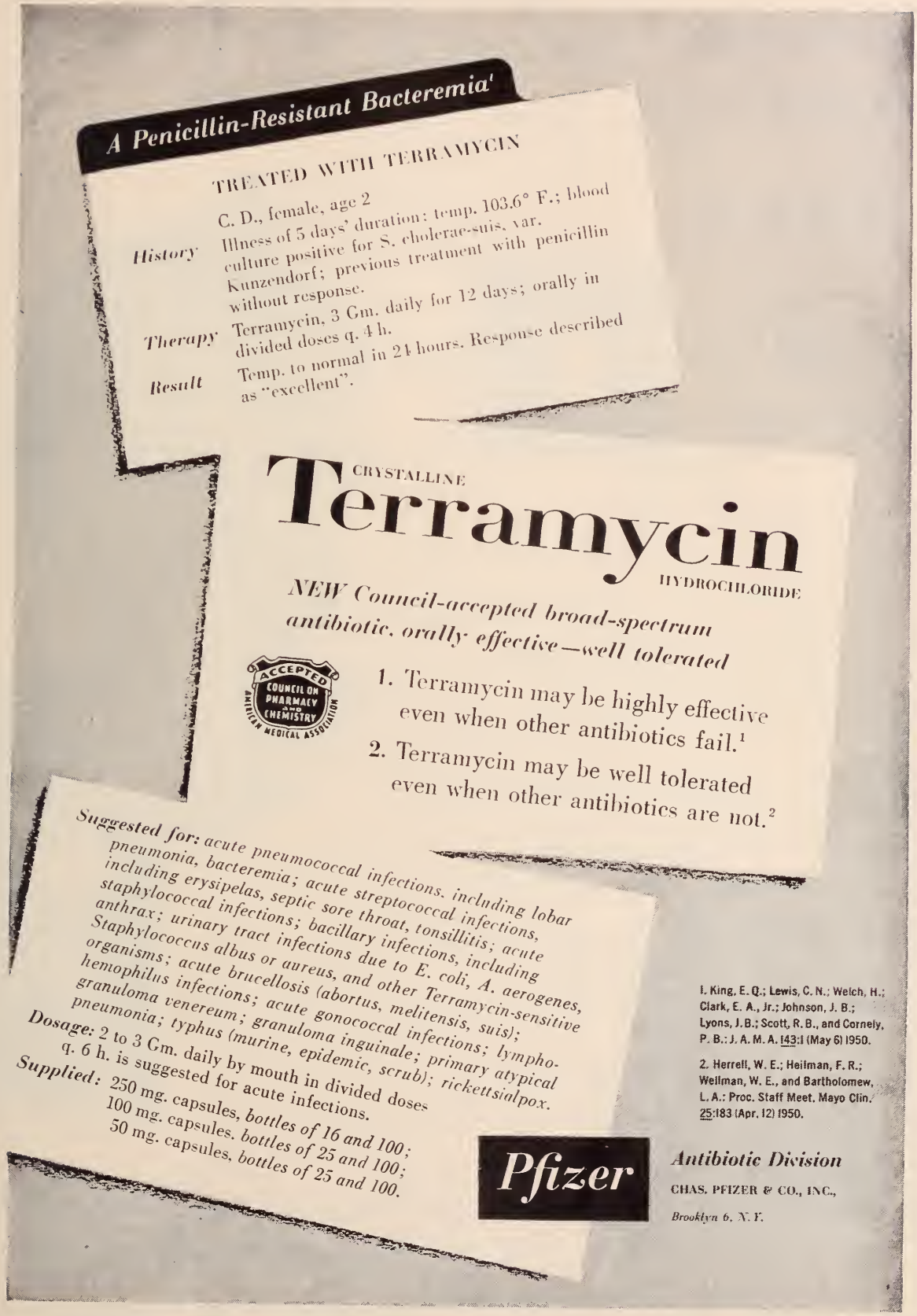
While individualization of dosage is essential for maximum therapeutic benefit, in the majority of patients a response to Veriloid is usually obtained from the average dose of 2.0 mg. to 5.0 mg. three or four times daily after meals and at bedtime. Dosage adjustment to suit the responsiveness of the individual patient can be accomplished in a week or two.

Veriloid is available on prescription at all pharmacies in 1.0 mg. tablets; bottles of 100, 200, 500 and 1000. Literature sent on request.

*Trade Mark of Riker Laboratories, Inc.

**RIKER LABORATORIES, INC.**
8480 BEVERLY BOULEVARD • LOS ANGELES 48, CALIFORNIA

BIOLOGICALLY STANDARDIZED FOR HYPOTENSIVE POTENCY IN MAMMALS


A Penicillin-Resistant Bacteremia[1]
TREATED WITH TERRAMYCIN
History
C. D., female, age 2
Illness of 5 days' duration: temp. 103.6° F.; blood culture positive for S. cholerae-suis, var. Kunzendorf; previous treatment with penicillin without response.
Therapy
Terramycin, 3 Gm. daily for 12 days; orally in divided doses q. 4 h.
Result
Temp. to normal in 24 hours. Response described as "excellent".
CRYSTALLINE
Terramycin
HYDROCHLORIDE
NEW Council-accepted broad-spectrum antibiotic, orally effective—well tolerated
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION
1. Terramycin may be highly effective even when other antibiotics fail.[1]
2. Terramycin may be well tolerated even when other antibiotics are not.[2]
Suggested for: acute pneumococcal infections, including lobar pneumonia, bacteremia; acute streptococcal infections, including erysipelas, septic sore throat, tonsillitis; acute staphylococcal infections; bacillary infections, including anthrax; urinary tract infections due to E. coli, A. aerogenes, Staphylococcus albus or aureus, and other Terramycin-sensitive organisms; acute brucellosis (abortus, melitensis, suis); hemophilus infections; acute gonococcal infections; lymphogranuloma venereum; granuloma inguinale; primary atypical pneumonia; typhus (murine, epidemic, scrub); rickettsialpox.
Dosage: 2 to 3 Gm. daily by mouth in divided doses q. 6 h. is suggested for acute infections.
Supplied: 250 mg. capsules, bottles of 16 and 100; 100 mg. capsules, bottles of 25 and 100; 50 mg. capsules, bottles of 25 and 100.
1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R. B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.
2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.
Pfizer
Antibiotic Division
CHAS. PFIZER & CO., INC.,
Brooklyn 6, N. Y.

*Dispersible*
**DRISDOL®**
**WITH**
**VITAMIN A**

a+d



COMPLETELY
*Milk*
*Diffusible*



Drisdol with Vitamin A administered in milk becomes an integral part of the child's diet. It diffuses completely in milk, orange juice and other liquids without an oily film, does not separate, float or tend to adhere to nursing bottle or nipple. May also be given on the tongue or in solid foods.

Drisdol with Vitamin A contains per gram 50,000 units of vitamin A and 10,000 units of crystalline vitamin $D_2$ (calciferol). Each drop delivers 1250 vitamin A units and 250 vitamin D units.

**Dosage** for infants, 2 drops; for older children and adults, from 4 to 6 drops daily in milk.

Supplied in bottles of 10 cc. and 50 cc. with dropper.

Also Drisdol in Propylene Glycol (10,000 units of vitamin $D_2$ per gram) in bottles of 5 cc., 10 cc. and 50 cc.

*To help build a sound structure and promote growth*

Drisdol, trademark reg. U. S. & Canada, brand of crystalline vitamin $D_2$ (calciferol)

*Winthrop-Stearns* INC.
NEW YORK, N. Y. WINDSOR, ONT.

*NOW!*

*stable*

*crystalline*

# Sodium Penicillin G

## *by Tongue, by Lung, by G. I. Tract*



*By Tongue:*

Sublingual PENALEV tablets (50,000 or 100,000 units) are rapidly absorbed, quickly create therapeutic penicillin blood levels.



*By Lung:*

Potent penicillin G aerosol solutions can be prepared readily by dissolving PENALEV tablets in water or normal saline.



*By G. I. Tract:*

PENALEV tablets dissolve promptly and completely in milk, fruit juices, or infant formulas, without appreciably changing their tastes.




*Penalev*

Soluble tablets sodium penicillin G: 50,000 and 100,000 units; vials of 12 tablets crystalline. Sharp & Dohme, Philadelphia 1, Pa.

# Penalev®

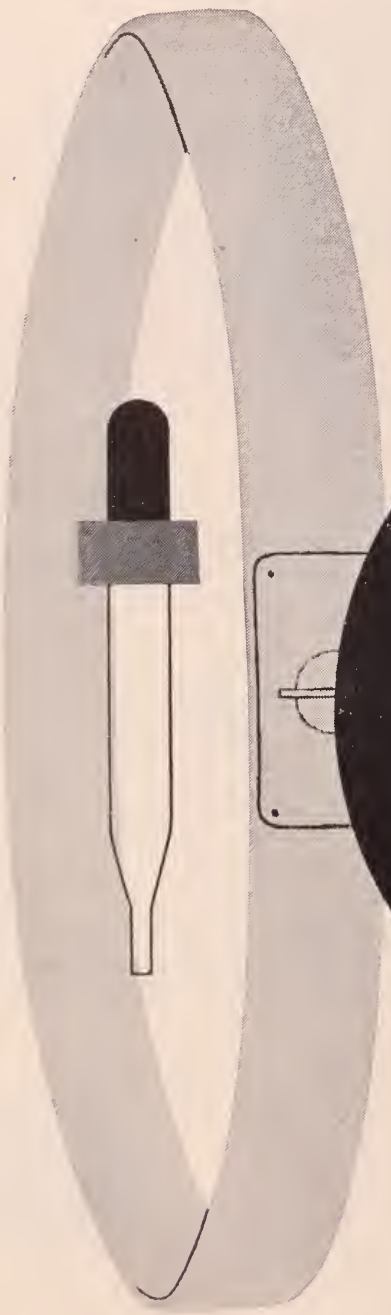
SHARP & DOHME

Soluble Tablets Crystalline

*Sodium Penicillin G*

**"Of all the medications tried for treatment of the common cold during my thirteen years as Chief of Otolaryngology at this school*, [Par-Pen] has proved the most satisfactory."**

*Furlong, T.F., Jr.: Clinical Test of a New Spray, Arch. Otolaryng. 48:658.*
**The Pennsylvania School for the Deaf, Philadelphia*



**POTENT BACTERIOSTASIS** Par-Pen provides the potent antibacterial action of 5000 units of penicillin per cc. . . . plus the vasoconstriction of 'Paredrine' Hydrobromide, 1%.

**DEEP PENETRATION** Penicillin in solution penetrates the tissues more readily than the sulfonamides or tyrothricin, reaching deeply embedded organisms.

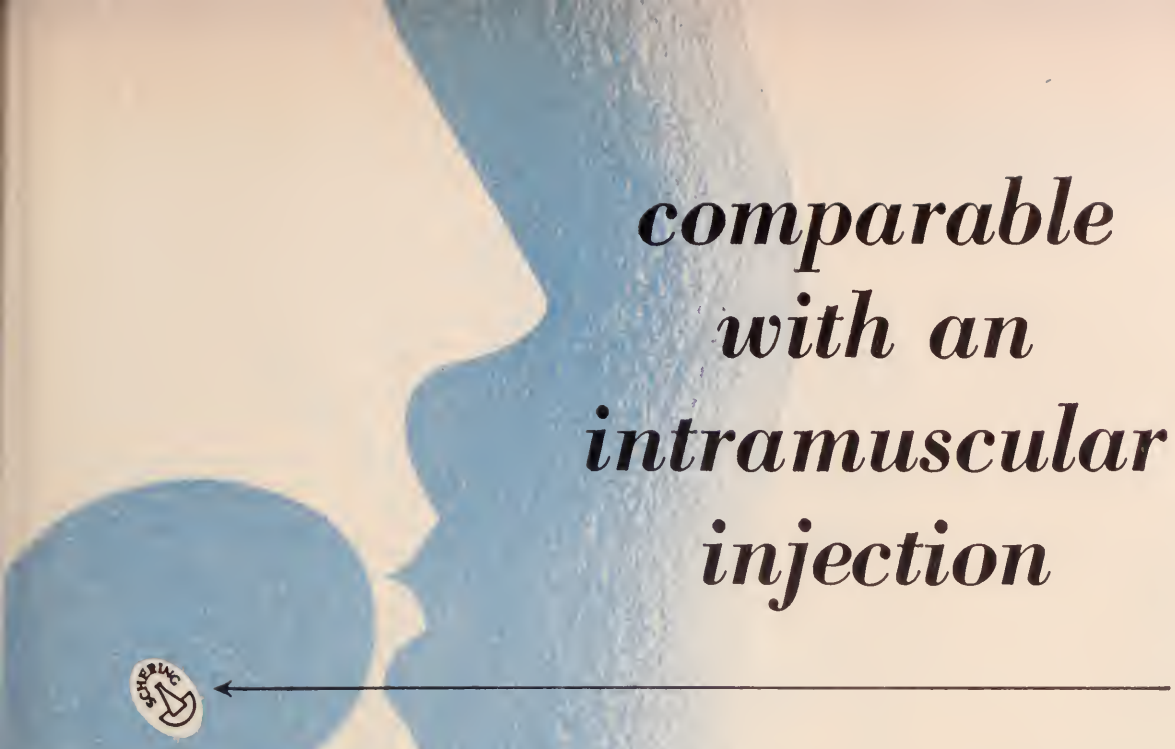
# Par-Pen

the penicillin-vasoconstrictor for intranasal use

Now packaged in convenient ½ fl. oz. bottles.

'Paredrine' & 'Par-Pen' T.M. Reg. U.S. Pat. Off.

*Smith, Kline & French Laboratories, Philadelphia*



# *comparable with an intramuscular injection*

Simple, practical and convenient, Schering's BUCCAL Tablets offer "parenteral hormone therapy by mouth" with little sacrifice of potency. Dissolved in POLYHYDROL* base, a solid solvent, the steroid hormones are absorbed directly from the oral mucosa. Early hepatic inactivation is obviated permitting a clinical effect "by mouth" comparable with that of an intramuscular injection.

# BUCCAL TABLETS

Indicated in adrenal insufficiency—**CORTATE**® Buccal Tablets;
in male hypogonadism—**ORETON**® Buccal Tablets;
in the menopausal syndrome—**PROGYNON**® Buccal Tablets;
in habitual abortion—**PROLUTON**® Buccal Tablets.

***Packaging:*** CORTATE Buccal Tablets (Desoxycorticosterone Acetate U.S.P.) 2 mg.; ORETON Buccal Tablets (Testosterone Propionate U.S.P.) 2.5 and 5 mg.; PROGYNON Buccal Tablets (Estradiol U.S.P.) 0.125 and 0.25 mg. and PROLUTON Buccal Tablets (Progesterone U.S.P.) 10 mg. – in bottles of 30 and 100.

*T.M.

Schering **CORPORATION**
**BLOOMFIELD, N. J.**

BUCCAL TABLETS

SCHERING

*for assured assay...*

**Sol Dex**
**DROPS**



*Enlarged approximately 250 times*

# VITAMIN B12 (CRYSTALLINE)

*in Drop Dosage Form*

## FOR GROWTH AND APPETITE
**effective • palatable • convenient**

Stabilized to contain per cc.
*(approx. 20 drops)*
. . . . 10 micrograms Vitamin $B_{12}$

"The only noticeable clinical changes after $B_{12}$ administration were those of increased physical vigor, alertness, better general behavior, but above all, a definite increase in appetite."
*– Wetzel, N. C., et al., Science 110:65*

*Available in bottles containing 15 cc. at most drug stores. For samples or further information, write:*

S. M. PHARMACEUTICALS
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# HIGHER NEW ANTIRHEUMATIC THERAPY *SALICYLATE LEVELS* VITAMIN C PROTECTION

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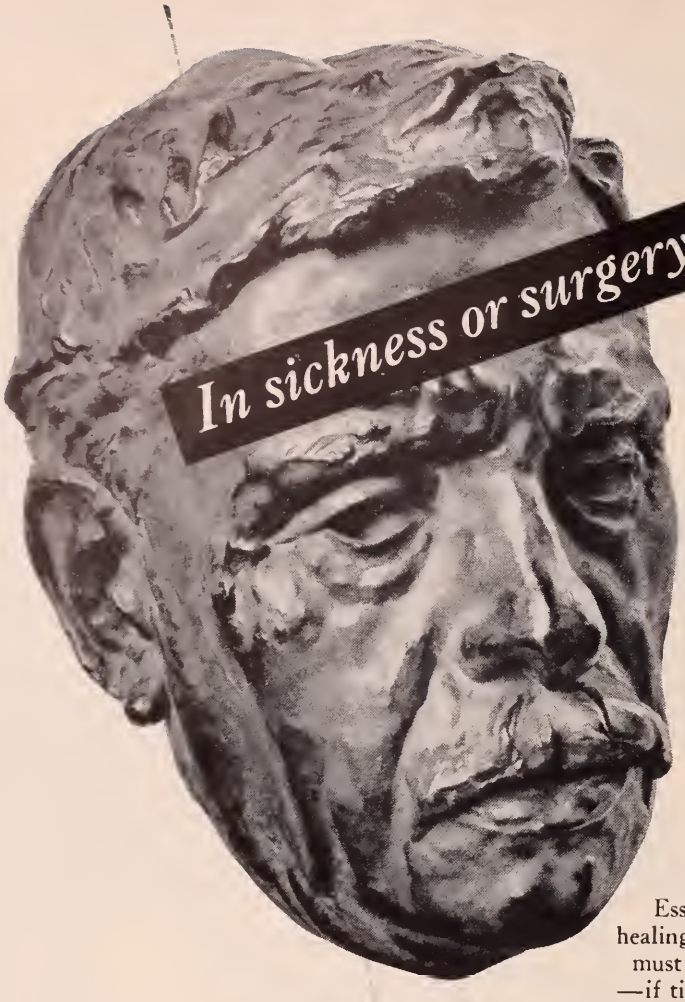
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**REFERENCES:** 1. Coller, F. A. and DeWeese, M. S.: Preoperative and Postoperative Care, J.A.M.A., 141:641, 1949. 2. Jolliffe, N. and Smith, J. J.: Med. Clin. North America, 27:567, 1943. 3. Kruse, H. D.: Proc. Conf. Convalescent Care, New York Acad. Med., 1940.
4. Spies, T. D.: Med. Clin. North America, 27:273, 1943.

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1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet. & Gynec. *57*:541, 1949
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*A 19" x 12" reproduction of this illustration by Robert Riggs is available upon request.*

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Kelp is first brought up from the bottom of the sea and then carried to a mountaintop in the process of becoming the "laboratory dining table" for germs. The cool air bleaches it nearly as white as the surrounding snow; oriental seaweed then becomes commercial agar. This material is essential to the bacteriologist because it makes possible the preparation of pure bacterial cultures in solid media which do not melt during incubation. Used in both research and production, agar continues to assist the Lilly Laboratories in furnishing physicians with dependable biologicals.


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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 98, No. 4 October, 1950

## TREATMENT PLUS

A rehabilitated patient is the objective of successful treatment. This concept is gaining momentum today and, as a result, rehabilitation has become an important phase of physical medicine. Medical care is not complete until the disabled person is trained to live and work with what he has left.

It is customary for many physicians to remind their heart patients to avoid respiratory infections and not to over-exert. This is the extent of their advice. But the question as to what can be done without jeopardizing his heart condition is neglected. In addition, there must be many short cuts that allow individuals more leeway in order to enjoy an existence that approaches normal. This brings us into the field of rehabilitation.

The American Heart Association, for example, has a pamphlet entitled "The Heart of the Home" in which many of the experience of cardiologists and heart patients have been pooled to make it easier to work about the house. There is a plan for a model kitchen which permits cooking and dishwashing with the least amount of effort. By sitting in one spot, the heart patient is able to prepare an entire meal without too much wear and tear on the "old ticker." This is practical advice and there is no reason why it cannot be carried out into other fields provided physicians and patients are willing to analyze the problem.

The Institute of Physical Medicine and Rehabilitation of New York University has compiled a manual of self-help devices for rehabilitation. It contains suggestions that will help the spastic and the paraplegic to become more self-sufficient. A small metal cuff, for eaxmple, can be made to fit over the hand of a handicapped individual to hold eating utensils, toothbrush, comb, etc. This gadget can be made from scrap material and is of estimable value for those who do not have sufficient power to grasp a small handle. This means the difference between feeding oneself or having to be fed by a nurse or member of the family. It is simple, yet how often do we recommend that such devices be utilized?

Many other similar gadgets are described including a rack for holding playing cards, a telephone holder, a training cup that cannot spill, and a description of how to lengthen a shoe horn with aluminum tubing in order to help a patient who cannot bend over to put on the shoes. Furthermore, the shores are equipped with zippers and a small hook can also be attached to grasp the handle of the zipper.

Rehabilitation extends into many fields. The diabetic finds he is denied work because of his condition. But this need not occur especially

with the diabetic who knows how to take care of himself. Since the physician knows his patients, he should go out of his way to help the individual who is cooperative because such a person can work without endangering his or the life of others.

## DERMATOLOGY TODAY AND TOMORROW

Many believe that dermatology is in need of a transfusion. It is argued that specialists in this field often confine their consultation to examining the skin and writing a prescription for a stimulating or soothing ointment. These remedies often are empirical because the cause is not known. The situation is bound to change in the future and we predict that the dermatologist will become more versed in internal medicine. He will consider rashes and other types of skin lesions to be outward manifestations of internal disturbances. This is reasonable inasmuch as each year more and more neratological conditions are added to the field of internal medicine. The collagen disorders fall into this category particularly with lupus erythematosus and dermatomyositis. Boeck's sarcoid is another example, and every day we hear more and more of the relationship between psoriasis and rheumatoid arthritis. Allergy and psychosomatic medicine already have made sizable dents into this field. No doubt in the future more internists will take up dermatology or, better, more dermatologists will delve into internal medicine.

## THE CONTROL OF TUBERCULOSIS

Considerable attention has recently been given to BCG vaccination in the public press. From this publicity the impression might be gained that this procedure alone holds promise of real control of tuberculosis. Since such an impression might postpone indefinitely the establishment and extension of accepted control measures, this statement of the status of vaccination in tuberculosis control programs is issued.

1) Control measures in tuberculosis should be directed at eradication of the disease as a major cause of death or disability.

2) The marked improvement in tuberculosis mortality figures, particularly for the ages under 30, demonstrates the effectiveness of the present control program.

3) The low rate in children and the continuing high rates in adults over 50 emphasize the location of the problem at the older age levels rather than in children. Under these circumstances, the efficiency of a method of tuberculosis control would be measured by its effect on the mortality from tuberculosis in the older age group, rather than in children.

4) The addition of a vaccine to the present control program requires both careful and adequate consideration. Of the vaccines proposed, BCG has been used most widely and is the one most often discussed.

5) This has been used for more than 25 years and recently many millions of people have been vaccinated. However, it must be stated that there is no evidence that meets strict scientific requirements demonstrating that BCG affects the control of tuberculosis, despite the very suggestive results of a few studies.

6) Because of the above fact and because there is no general agreement among investigators anywhere in the world on such fundamental matters as the preparation of vaccine, the method of vaccination, what constitutes a successful vaccination, how resulting immunity may be measured, how long such immunity lasts, etc., the procedure would seem to be still in the investigational period.

7) It is therefore recommended that investigation of vaccination in tuberculosis be continued and increased under standard and stringently controlled conditions. This investigation should be designed to determine if the vaccine is indeed effective and what the limitations of its use might be. It would seem desirable that in each country, one agency preferably the official health agency, should save control of the investigation.

8) Until this has been determined and until these controlled studies completed, the use of BCG vaccine should be limited to such investigative studies.

9) At the present time the methods which have proved effective in tuberculosis control should be increasingly applied to all segments of the population, regardless of decreasing mortality figures, so long as tuberculosis remains an important cause of death. These measures in-

clude mass x-ray case finding, early diagnosis, rapid institution of treatment, isolation of open cases, and the restoration of the patient to normal life.

*Report, Council on the Management and Treatment of Diseases of the Chest. American College of Chest Physicians*

## A.M.A. INTERIN SESSION IN CLEVELAND

The Fourth Clinical Session of the American Medical Association, designed primarily for the general practitioner, will be held in Cleveland, December 5-8.

The scientific sessions and the scientific and technical exhibits will be presented in the Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held in the Statler Hotel. These sessions of the body elected to govern the affairs of the A.M.A. are attracting more and more non-delegate physicians each year.

Clinical teachers with recognized ability as speakers will headline the scientific demonstrations. Actual cases will be presented and discussed. Diagnoses, treatment and preventive measures as they fit into daily practice will receive the greatest attention.

Each clinical session will be limited to an attendance of 100 physicians. These small groups will make it possible for the general practitioner to enter actively into the discussion and to inquire about his own cases. Leading men in each of the fields under discussion will be available to help with the problems presented.

Once again color television will take its place on the program. A schedule of surgery, clinical treatment and examination will be telecast from the Western Reserve School of Medicine to the auditorium.

The annual General Practitioner Award has come to be regarded as one of medicine's highest honors and a definite step toward increasing the recognition of the family doctor. This year's selection will be made at the Cleveland meeting.

The steadily climbing registration of general practitioners at the clinical sessions and the comments of those participating indicate these meetings are valuable means of keeping abreast of developments in medicine. It is hoped that a record number of physicians will take advantage of the opportunity in December to attend. The program has been designed with that in mind.

## RARE TYPE OF CANCER MAY FOLLOW NAIL INJURY

A rare type of cancer arising in the finger or toe nails is reported by a Peoria doctor in the September 2 Journal of the American Medical Association.

Appearance of a sore between the cuticle and the nail is a distinguishing characteristic of this cancer, Dr. Lyle W. Russell says. Symptoms such as swelling and moderate pain easily may lead to delayed recognition of the tumor and confusion with other conditions, he points out.

The cancer may appear as a small, yellowish crater which fails to heal and if neglected may invade the bone, according to Dr. Russell. Amputation of the finger or toe is the recommended treatment and the outlook for cure usually is good unless spread of the cancer to another part of the body has occurred prior to the surgery.

Injury appears to be a possible inciting cause in the formation of this type of cancer, Dr. Russell says. In 11 of 20 cases reported, a deep puncture wound between the nail and nail bed or other injury to this area preceded the diagnosis of cancer by six months to 18 years.

# CORRESPONDENCE




## "YOUR MENTAL HOSPITALS" TINLEY PARK STATE HOSPITAL

Land has been purchased and construction has been started on a new forty million dollar mental hospital in Illinois. This will be the sixteenth mental institution in this State. The other State Institutions are: 9 — *Mental Hospitals at* Chicago, Elgin, Kankakee, Manteno, East Moline, Peoria, Jacksonville, Alton and Anna. 2 — *Hospitals for the Mentally Deficient at* Lincoln and Dixon 1 — *Hospital for the Criminally Insane* Illinois Security Hospital at Chester 2 — *Research Institutions* Illinois Neuropsychiatric Institute at Chicago, Galesburg State Research Hospital at Galesburg 1 — *For Child Psychiatry* Institute for Juvenile Research at Chicago.

Over four hundred acres of land was purchased on the southern outskirts of Cook County at 183rd Street and Harlem Avenue in Tinley Park, Illinois. Numerous meetings and conferences have been held with members of the State Welfare Department, the State Architects and other experts throughout the country in the development of plans for a modern institution which would function efficiently, yet retain all the desirable features of pleasant and attractive surroundings with a homelike atmosphere. The firm of Skidmore, Owings and Merrill has been engaged as the Associate Architects for the development of detailed plans.

The institution will care for a maximum of 4,000 patients. It will consist of two complete units; namely, a general psychiatric unit of 2,500 beds for the care and treatment of mental patients, and a self-contained unit for 1,500 mental patients with active pulmonary tuberculosis. The mental cases with tuberculosis will be transferred to Tinley Park from the other northern institutions for better medical care and pulmonary surgery.

The General Psychiatric Unit will consist primarily of one story buildings interconnected by tunnels and underground passageways. A multi-story building five or six stories high, will be constructed to house the acute medical and surgical units, the infirmaries and the special research units. An extensive receiving, diagnostic center and active psychiatric treatment building will provide a miximum benefit of examination and early treatment for the newly admitted patients.

Employees will be housed in quarters varying from single rooms in a multi-story building to small apartments and cottages. Housing will be provided for approximately two-thirds of the six hundred employees.

Construction has been started, and the current 1949-1951 appropriation of two and a quarter

million dollars will provide the basic utilities; namely, the wells, sewer lines, incinerator, sewage treatment plant, railroad sidings and roadways, and the power plant. The total cost of the institution is estimated at forty million dollars. It is hoped that funds will be obtained from the State Legislature to complete this new State Hospital within the next eight to ten years.

## CLINICS FOR CRIPPLED CHILDREN FOR NOVEMBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the November schedule of clinics for physically handicapped children. The Division will conduct 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services:

The November clinics are:

November 1—Joliet, Will Co. TB Sanitarium
November 2—Pittsfield, Illini Community Hospital
November 7—Shelbyville, Veterans Center
November 8—Hinsdale, Hinsdale Sanitarium
November 9—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
November 9—DuQuoin, Marshall Browning pital
November 9—Springfield, St. John's Hospital
November 10—Chicago Heights (Rheumatic Fever), St. James Hospital
November 14—Peoria, St. Francis Hospital
November 14—E. St. Louis, St. Mary's Hospital
November 15—Evergreen Park, Little Company of Mary
November 15—Sterling, Sterling Public Hospital
November 16—Rockford, St. Anthony's Hospital
November 17—Chicago Heights (Rheumatic Fever), St. James Hospital
November 21—Casey, High School
November 28—Peoria, St. Francis Hospital
November 28—Effingham (Rheumatic Fever), St. Anthony's Emergency Hospital
November 29—Springfield, (Cerebral Palsy), Memorial Hospital
November 29—Alton, Alton Memorial Hospital
November 30—Bloomington, St. Joseph's Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

## RADIOLOGICAL SOCIETY OF NORTH AMERICA

Announcement is made by Warren W. Furey, M.D. of Chicago, president of the Radiological Society of North America, that the 36th Annual Meeting of the Society will be held in Chicago, December 10 through the 15th.

Headquarters for the meeting will be the Palmer House in which all scientific and technical sessions will be held. Scientific exhibits are also to be displayed in the hotel.

More than 60 papers as well as refresher courses feature the convention program.

Dr. Wendel G. Scott of St. Louis, Missouri, will present the annual Carmen Lecture. All members of the medical profession are welcome and invited.

## AMERICAN COLLEGE OF CHEST PHYSICIANS PRIZE AWARD

The Board of Regents of the American College of Chest Physicians offers a cash prize award of two hundred and fifty dollars to be given annually for the best original contribution, preferably by a young investigator, on any phase relating to chest disease. The prize is open to contestants of other countries as well as those residing in the United States. The winning contribution will be selected by a board of impartial judges and the award, together with a certificate of merit, will be made at the forthcoming annual meeting of the College to be held in Atlantic City, New Jersey, June 7-10, 1951.

The College reserves the right to invite the winner to present his contribution at the annual meeting and to publish the essay in its official publication, *Diseases Of The Chest*. Contestants are advised to study the format of *Diseases Of The Chest* as to the length, form and arrangement of illustrations to guide them in the preparation of the manuscript.

The following conditions must be observed: 1. Five copies of the manuscript, typewritten in English should be submitted to the executive Office of the College, 500 North Dearborn Street, Chicago 10, Illinois not later than April 1, 1951. 2. The only means of indentification of the author or authors shall be a motto or other device on the title page and a sealed envelope, bearing the same motto or device on the outside, enclosing the name of the author or authors.

## ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Columbus, Ohio, May 24, 25 and 26, 1951, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than March 1, 1951. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

## AUTHORIZE APPOINTMENT OF WOMEN DOCTORS AS RESERVE CORPS OFFICERS

Appointment and concurrent assignment to active duty as Reserve Officers of women physicians, dentists, and allied specialists, has been authorized, according to the Department of the Army.

This marks the first time authorization has been given for women to be commissioned in the Medical, Dental, Veterinary, and Medical Service Corps Reserves. They will be brought on duty under regulations currently providing for the commissioning of male officers in these Corps. Some women did serve in the Army as physicians and technicians during World War II, but their commissions have expired.

As Reserve offiicers on active duty, these women will be given opportunities for clinical practice and advancement which are now available to male officers in comparable grades, Major General R. W. Bliss, Surgeon General of the Army, pointed out. Appointments will be in grades from first lieutenant to colonel, depending upon age, experience, and professional qualifications. The pay, allowances, dependency and retirement benefits which accrue to male officers will apply to the women medical reservists. Women physicians and dentists will also draw the $100 a month professional pay allowed above the base pay of their commissioned rank. They will be eligible for service in every type of military medical facility, with the exception of forward medical installations in combat zones.

## SECTIONAL MEETING OF AMERICAN COLLEGE OF SURGEONS

There will be a Sectional Meeting of the American College of Surgeons in St. Louis on January 22 and 23, 1951, and we would appreciate it very much if you would run an announcement of it in your state journal for the ensuing issues or in as many as you deem proper.

As you know, the members of the College of Surgeons are invited and also any other doctors who wish to attend. I think there will be a reg-

istration fee of $5.00 for non-members but, as this is the first year this has been done, I am as yet not sure about it.

The states covered are Missouri, South Dakota, North Dakota, Minnesota, Wisconsin, Iowa, Kansas, Louisiana, Arkansas, Mississippi, Illinois and Indiana, and an excellent and practical program has been arranged. There will be an extra day of operative clinics besides the scheduled days.

The meeting is on January 22 and 23, 1951, with headquarters and the program at Hotel Statler.

James Barrett Brown, M.D.
Chairman, Sectional Meeting
American College of Surgeons
St. Louis, Missouri, Hotel Statler

## AMERICAN COLLEGE OF PHYSICIANS TO MEET IN MADISON

The Midwest Regional Meeting of the American College of Physicians will be held at the Memorial Union Theater on the campus of the University of Wisconsin in Madison, Wisconsin, Saturday, November 18, 1950. Registration will begin at 8:00 A.M. and the scientific meetings will be followed by a social hour and dinner to be held at the Loraine Hotel in Madison, beginning at 5:30 P.M. The day will be filled by the presentation of scientific papers. In addition, a scientific exhibit will be provided in the foyer of the Memorial Union Theater.

Entertainment has been planned for the ladies, including a tea on Saturday afternoon at which Mrs. Oscar Rennebohm, wife of the Governor of Wisconsin, will be hostess. Tea will be served in the Governor's Mansion on the shores of Lake Mendota.

It must be emphasized that this meeting is open to all physicians whether or not they are members of the American College of Physicians. All physicians and their wives are cordially invited to be present and to participate.

Reservations for luncheon and dinner should be made immediately through Dr. H. M. Coon, 1300 University Avenue, Madison 6, Wisconsin.

## INTRA-EPITHELIAL CARCINOMA OF THE CERVIX

There are many reasons why total hysterectomy is the treatment of choice for intra-epithelial malignancy. The most conclusive reason is that in all cases that have been observed for an appreciable period there have been no recurrences of the disease following complete removal of the uterus. The largest group of such patients observed for a period of time is probably that of Galvin and Telinde. They have a series of sixty-seven cases where the uterus was removed for noninvasive carcinoma that have been observed for a period of from six months to eight years without any evidence of recurrence. Since the average age of the patients who develop intra-epithelial carcinoma is over thirty-five, the majority of these women are near the end of their reproductive period; therefore, preservation of the uterus for pregnancy is unimportant. By complete hysterectomy there is assured removal of all cervical epithelium as well as the removal of pathologic pelvic conditions which have been recognized or have been unrecognized preoperatively. It is of some importance to remove a small cuff of vaginal mucosa surrounding the cervix to be certain that no malignant tissue remains. In performing hysterectomy for this condition, one may leave one or both ovaries in younger women because it has been observed that the ovary is not a site of early metastasis of cervical carcinoma. That the remaining ovary may be a source of carcinogenic estrogen is of no real concern since it has never been proved that estrogen has any effect on the development or growth of cervical carcinoma. *Except: Intra-Epithelial Carcinoma of the Cervix, David A. Bickel, M.D., and Carl S Culbertson, M.D., South Bend, The Journal of the Indiana State Medical Association, April 1950.*

# ORIGINAL ARTICLES



# The Prevention of Respiratory Infections in Children, Including Sulfonamide Prophylaxis

**J. Keller Mack, M.D.**
**Springfield**

The most common complaint among children in this climate during the winter is that of repeated colds, sore throats, and coughs. The mother brings the child of from three to nine years to the office, and is worried because he has been having repeated respiratory infections. The child does not eat well and often has lost weight. He does not have as much "pep" as usual and appears generally run-down. In addition, he may have a runny nose and his cough may alarm other patients in the waiting room, who think he has pneumonia or whooping cough.

Even though repeated respiratory infections do not usually impair the child's growth or development, the problem is nevertheless an important one. These infections are the most frequent cause of illness in children. They cause a great deal of disability, loss of time from school, and medical expense. Acute complications are frequent and sometimes serious. Frequent and repeated infections are often the cause of anorexia, malnutrition, and secondary hypochromic anemia. Chronic suppurative sinusitis, otitis media and bronchitis occur frequently enough to be a real danger. Therefore, when a child presents himself because of repeated infections, we should not shrug our shoulders and tell the mother to forget about it—that the child will outgrow it.

Because of our lack of knowledge concerning viruses, a limitation of the discussion must be interposed here. Since we have no vaccines (except against influenza) or drugs which are effective against respiratory viruses, the only thing we can do in the prevention of virus infections

Presented before the Section on Pediatrics, 109th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1949.

is to put our patient into the best possible physical condition and keep his environment as healthful as possible. Therefore, this discussion will not deal with the "common cold", but only with its complications or with respiratory infections which are of bacterial etiology. The actual incidence of viral etiology of respiratory infections has not been determined. Recently it has become fashionable to attribute a majority of respiratory infections to viruses. It is not within the scope of this paper to review the literature on this subject. When one has done so he is still at a loss because of conflicting evidence due to lack of laboratory methods of identifying viruses. Practical clinical experience shows that during most of the year respiratory infections respond dramatically to chemotherapy or antibiotics, while at others, viruses or resistant bacterial strains seem to play a prominent role. For example, the latter ones have been rather frequent during March and April of this year. (1949) However, even if we eliminate viruses there are still a great many respiratory infections in children which we can help to prevent.

It is well known that children are more susceptible to respiratory infections than are adults, which indicates that this problem is primarily one of lack of immunity to the causative organisms. By repeated exposure to infections the child, over a period of years, gradually builds up an immunity. Time does not permit a detailed discussion of this opinion, but it is generally accepted as far as the bacterial (not virus) infections are concerned. Therefore, the logical solution would be to do something to help the child build up his immunity more rapidly. The only direct approach which has been suggested is the administration of respiratory vaccines, the results of which have been very disappointing. The difficulty probably arises from the fact that there are so many different strains of streptococci, pneumococci, etc., each of which is immunologically more or less distinct from the others. The problem is further complicated by the fact that immunity to the respiratory organisms is very difficult to measure in the laboratory, thus making research along these lines rather unproductive. Therefore, an effective respiratory vaccine has not been developed. Consequently, in our present lack of knowledge concerning this subject we must turn to other less direct methods of solving our problem.

In the prevention of repeated respiratory infections there is no general rule to follow. Each patient must be evaluated as an individual problem. First, it must be decided whether or not the patient under consideration really does have too many infections of more than average severity. Practically all children have some respiratory infections every winter, and one must not be unduly influenced by an over-anxious mother. The duration of infections and the occurrence of frequent complications are more important than the number of episodes during a winter season. A thorough history, a careful physical examination, followed by such laboratory work as may be indicated, are, of course, essential.

If a dietary or vitamin deficiency is found, attempts should be made to correct it. Proper hygiene should be explained to the mother. In this connection the most common fault is the overheating of homes, with the production of air that is so dry that it injures the membranes of the repiratory tract.

It is not the purpose of this paper to discuss at any length the tonsil and adenoid problem. However, since chronic infection in these lymphoid structures is a common cause of repeated respiratory symptoms, the problem must be mentioned for the sake of completeness. The most important point to remember is that each patient must be individually evaluated. When chronically infected, the removal of tonsils and adenoids may give excellent results, but it cannot be said too often that the presence of repeated respiratory symptoms alone is not an indication for removal. Many of the children that come to us complaining of frequent infections have already had these structures removed. Because pharyngeal lymphoid tissue serves a useful purpose, especially in young children under the age of 6 years, indiscriminate surgery in this age group should be condemned. Where symptoms of obstructed breathing or frequent otitis media are present in young children, it is usually advisable to remove only the adenoids.

The indications for tonsillectomy and adenoidectomy may be summarized as follows: The history is probably more important than the physical examination. The history should reveal repeated attacks of tonsillitis or sore throat, symptoms of adenoid obstruction, or repeated otitis media.

Repeated respiratory infections of a general nature may be used as an indication for a tonsillectomy in an older child with the reservation that results may be disappointing. Concerning the physical examination, it has been repeatedly stated that enlarged tonsils do not necessarily need to be removed, even in older children. The appearance of the tonsils is very misleading. Persistent enlargement of the cervical glands is more important, probably indicates some absorption of toxic products, and may be used as an indication for tonsillectomy. Removal of tonsils and adenoids for purely allergic conditions is contraindicated.

We come then, in the evaluation of our child with repeated respiratory infections, to the point at which we have done everything possible to improve the nutrition and hygiene, and the tonsils and adenoids have been removed if indicated. What can then be done for a child who continues to have repeated respiratory infections? As previously stated, there is very little we can do to raise the child's natural immunity. However, I believe that there is a useful therapeutic procedure now at our command, which can bring about good results in selected cases and with proper care and observation. I refer to the prophylactic daily administration of sulfonamides during the so-called "respiratory season".

The value of sulfonamide or antibiotic prophylaxis of respiratory infections in children with rheumatic or certain types of congenital heart disease is now widely accepted.[1-12] Several large clinics have performed experiments in prophylaxis, using daily doses of oral penicillin.[13, 14] The cost of oral penicillin to private patients is practically prohibitive when used over a long period of time. Since sulfonamides are apparently as effective as penicillin and no more dangerous in the doses given, it was decided that sulfonamides should be used in the experiment to be described.

Much has been written about the large scale experiments carried out by both the Army and Navy during the war, on prophylactic use of sulfonamides in training camps. Without going into details, it is the concensus of opinion that this prophylaxis did reduce the incidence of streptococcic infections, rheumatic fever, meningococcic infections and other respiratory infections not of virus etiology. However, it must be stated that in these camps during the experiments there frequently developed strains of organisms which were resistant to sulfonamide drugs.[15, 16] This is thought to be due to an elimination of sulfonamide sensitive organisms and a consequent increase in the percentage of respiratory infections caused by resistant organisms in those camps. However, one consideration must be kept in mind in this connection. These Service experiments were carried out in camps in which all or a large part of the population was given prophylaxis and thus the sensitive organisms were almost completely eliminated from the environment. This consideration is not valid in a civilian community in which only a very small percentage of children would be taking daily sulfonamides. Adults and other children would continue to harbor sulfonamide sensitive organisms and these would continue to be the predominating organisms causing respiratory infections. A point in favor of this belief is that the large majority of acute respiratory infections in children respond promptly to treatment with sulfonamides. In addition, the crowding and congestion in barracks, mess halls, etc. of the service camps do not prevail in civilian communities. Therefore, since it has been pretty well established that respiratory infections due to sensitive organisms are greatly reduced, it follows that the child receiving sulfonamide prophylaxis would be protected against most of the respiratory infections. I believe that the above reasoning is valid, and therefore, that prophylaxis in selected cases should give better results than was obtained in the Army experiments.

Since the administration of sulfonamides is not without a certain risk, the question arises as to whether or not the procedure is warranted for the amount of good to be obtained, in other words, is this too big a gun to be wheeled out in such a battle? The answer to this question must be considered from two standpoints: First, the magnitude of the battle—it has been shown above that in young children repeated respiratory infections can be a great cause of disability with its consequent possibility of permanent damage. In the second place, is the use of sulfonamides too dangerous when given over a long period of time? Referring back to the Army and Navy studies, and also to studies among rheumatic children, it can be definitely stated that the oc-

currence of reactions to the small doses used is almost negligible. Very large numbers of patients have been involved in the experiments with a very low incidence of reaction. It is now pretty well established that rare reactions to small doses are usually due to an individual hypersensitivity to the drug. Sulfonamide reactions may manifest themselves as rashes, fever, hematuria, hemolytic anemia and granulocytopenia. If the patient is cooperative, and the proper precautions observed, as mentioned below, any real damage from such sensitivity can practically be eliminated.

During the past three winter seasons, 54 children were placed on daily sulfonamides for the prevention of respiratory infections. Their ages ranged from 2 to 15 years. Five of these were rheumatic fever patients, 6 were allergic (mostly asthma), others were normal children who were subject to respiratory infection and in whom no further local treatment was necessary. They have also been given an adequate diet, hygiene had been discussed, and added vitamins have been administered. The program for the administration of the sulfonamides has been as follows: The daily dosage has varied from 5 grs. in the child of 2 to 3 years, 7½ grs. from 4 to 7 years, 10 grs. from 8 to 10 years, and 15 grs. in the older children. Sulfamerazine is the drug of choice, administered either in liquid or tablet form. The daily dose is divided into two parts, one being given before breakfast and the other in the evening.

Blood counts have been done on the average of every two weeks for the first six weeks, since it has been shown that reactions which occur are most likely to come on at the beginning of treatment. After the first six weeks the children are seen for blood counts at about once a month. Urinalysis is also done periodically. Mothers were requested to report the occurrence of any unusual symptoms such as rash, vomiting, urinary symptoms, malaise, etc. Only patients and parents who were considered to be cooperative and intelligent were placed on such a regime. I do not believe it would be wise to institute this treatment unless you could be fairly sure that the patient would return for observation.

The 54 children who were given prophylactic sulfonamide therapy had had an average of 4 to 5 respiratory infections during the previous winter, not counting "common colds", with the exception of two of the rheumatic children, in whom the treatment was given to prevent infections which might cause a recurrence of rheumatic fever. Seven of the children were given the regime for two years. In the case of the asthmatic patients, it was felt that some of the attacks were initiated or accompanied by respiratory infections since they often had fever with attacks. The previous infections complained of were of all types, such as: colds, coughs, sinus infections, pharyngitis, tonsillitis, pneumonia, bronchitis, otitis media. It must be emphasized that these were the worst cases, selected only when the chief complaint was repeated infections with fever, and when it was felt that the parents would be cooperative.

After the institution of sulfonamide prophylaxis, the virtual absence of significant infections was spectacular. These children, who had previously been seen repeatedly by the author or other doctors, and who, according to their histories, had had an average of 4 or 5 febrile infections in a winter, would have been expected to experience a total of from 100 (about 2 per child) to 200 (4 per child) infections for the whole group. Instead of this incidence, there were only 14 instances of respiratory infection in the total series—and no child had more than one infection per season while on prophylactic treatment. These 14 instances required only a total of six office or house visits for infections. With two exceptions, these infections were all a mild involvement of the throat, ear or bronchus with temperatures not over 100 degrees. These two exceptions were cases of bronchitis which occurred during periods of widespread prevalence of virus infections, and which were probably of this etiology. One occurred in a rheumatic fever patient who was in the hospital at the time. The maximum temperature was 101 degrees and the infection was of short duration. The second had a maximum temperature of 102 degrees at a time when there was a virtual epidemic of virus pneumonia and bronchitis. The asthmatic children did require occasional office visits or house calls for asthma, but no attacks were associated with fever. In all the other children, mothers reported occasional mild cough or "common colds" which ran the usual course for several days without complications and required no visits. During these seasons there was a severe measles epidemic (1 patient had a mild earache) and 2 widepread

epidemics of virus pneumonia and bronchitis. These children not only fared better than they had previously but had fewer infections than their brothers or sisters and fewer infections than most normal children of their age.

Not included in the above figures is the case of a child in whom the regimen must be regarded as probably a complete failure. This boy of 18 months had had recurrent bronchitis of an asthmatic type since the age of 9 months. The cause of these recurrences could not be determined. No really allergic basis could be found, no congenital malformation demonstrated, and examination for pancreatic fibrosis was negative. Sulfonamide prophylaxis failed to prevent recurrences, but penicillin would usually give fairly prompt relief.

The mothers of all patients were pleased with the results of the treatment, but 4 of them stopped treatment of their own accord because they thought the child no longer needed it.

There was only one reaction to the sulfonamides but this child had to discontinue medication because of what was thought to be a reaction to the drug. This case is of interest because of the unusual nature of the reaction which was not an abnormality of the blood count or urine. The patient, a girl of 2 years, had had almost constant attacks of colds and coughs. She was well nourished and there was no evidence of cystic fibrosis of the pancreas. She was given sulfamerazine, 2½ grs. twice a day. After one month she suddenly developed fever with which there were no findings except an elevated leucocyte count with an essentially normal differential. The sulfamerazine was stopped and the temperature returned to normal. After several days the medication was restarted and one month later the same process was repeated. At the mother's request, the sulfamerazine was tried again but the same symptoms recurred after a month of medication. The child completely recovered each time with no ill effects. During this time the patient had no significant respiratory infections.

I would be the first to admit that this series is too small to furnish figures which would be valuable from a statistical point of view, but the results are so striking that it is hoped that further interest in the method will be stimulated.

## CONCLUSIONS

Respiratory infections can best be prevented, according to our present knowledge, by the following procedures:

1. Improvement of general hygiene, diet, living conditions.
2. Local treatment of pathology in the respiratory tract, after thorough study and conservative evaluation.
3. Daily administration of small doses of sulfonamide drugs from November through April, in selected cases.

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## DISCUSSION

Dr. Eugene T. McEnery: Dr. Mack emphasizes the point of hygiene and also brings up the fact of crowding. In the Chicago area, every once in a while we get a family that seemingly has one cold after another and you can stand on your head and give them this or that and they still have these colds.

The crowding factor certainly is important because in this family that I mentioned, I made a house call there and looked the situation over. There was a four-room apartment and in that four-room apartment six adults and two children were living. Well, the bathroom facilities for that number of patients were just terrifically inadequate to take care of any hygiene. That was the answer, as far as I was concerned, as to why the children had so many colds and coughs one right after another. The reason for it was because of crowding and because of inadequate bathroom facilities.

Dr. Cline is tremendously interested in allergy. Dr. Mack brought up the subject of allergy, and I think we would like to hear a few words about Dr. Cline's reaction to respiratory infections in reference to that.

Dr. Gerald M. Cline (Bloomington, Illinois): I have been interested in this subject for a number of years and each winter I have had a fair number of children on small dosages of a sulfa drug as a preventative of

upper respiratory infections. At first I was very enthusiastic about the results as a prophylaxis as well as most of us were about the results of treatment of active and severe upper respiratory diseases and their complications with the sulfa drugs. However, today and especially this last winter I, too, found sulfa prophylaxis and sulfa therapy alone quite unsatisfactory. In other words it took a combination of sulfa drugs with penicillin and at times streptomycin, aureomycin, etc. to control what seemed clinically to be the same type of infection we were dealing with three to five years ago. Either the bacterial flora has changed or a combination of resistant organisms has developed.

Will you all agree that this year we had more otitis media and nephritis as complications than we have seen for several years? The winter of 1946 produced a high percentage of pneumonias, 1947 very few pneumonias but many cases of diarrhoea; 1948 more pneumonias, very little diarrhoea but, as stated above, more otitis and nephritis.

We have not attempted to accurately check on the number taking the drug with evaluation of results, but off hand I quite well remember several families and parents so pleased with using sulfa as a prophylaxis one year that they will return each year and ask for a continuation of the drug. I can think of no one who has bitterly opposed its usage. Mainly because of the wide spread publicity in the literature concerning the dangers of producing patient resistance and organism resistance, I have used sulfa far less this past winter than in the winters mentioned before. There was a time when I had at least 75 private patients on a sulfa drug all winter long as a prophylaxis for upper respiratory infection. I know I used larger dosages than most anyone else. Not one time did I encounter any serious complications from the drug. I still have at least a dozen rheumatic children on the year-round small dosage schedule. Here again, in my hands, I feel this management has been quite successful. Therefore, personally I will go along with Doctor Mack and his ideas presented here at least until I am further convinced it is wrong.

Allergy and its part in the causation of frequent upper respiratory infections is no longer debatable. Certainly allergic children have more upper respiratory infections yet, in my opinion, the correction of the allergy alone which is most difficult because of the large number of dust sensitive cases will not compare in results with allergy and sulfa prophylaxis management. in my mind, the dusty feather pillow is our number one gangster always to be removed where one has a cold susceptibility; in fact, I will go along stating that no one should spend one-third of his life with his nose burried in the dirtiest article in the house. Today with commercially made dust proof encasings and, even better, rubber foam pillows, no cold susceptible child should be deprived of these encasings or pillows. I can assure you the results universally would be astounding. The child with ragweed hay fever and/or asthma is often more susceptible to colds and he, too, with the addition of carefully controlled hypo-sensitization to these allergens plus small doses of sulfa will have less colds during the winter. Again this is my personal opinion, which, I believe, agrees with Doctor Mack's ideas.

Anti-histamines also have in some cases reduced the number of colds in some children so until we find the universal method of prophylaxis and treatment of the common cold, there will be variable opinions as to this viewpoint.

Dr. A. R. Eveloff: I would like to emphasize the frequency with which allergy plays a part in a relatively large proportion of children with a history of persistent colds. In this group of patients one finds that the nose is apparently never normal, though there are periods when nasal symptons are more severe than others. If seen in the former period one is likely to find the nose to present a picture of allergic rhinitis, with abnormal numbers of eosinophils present in the nasal smear. In the latter period the nasal findings are those of an acute rhinitis. This group of children will have many fewer episodes of respiratory infection, if efforts are made to manage the allergy.

I should like to ask Dr. Mack if he thinks one need be concerned about the likelihood of making these children more resistant to subsequent therapeutic use of the antibiotics, after the use of small doses of the drugs in prophylaxis.

Dr. J. Keller Mack (Springfield, Illinois):[2] I, too, am very much interested in allergy. The patients that I considered allergic rhinitis because of history, physical exam or eosinophiles in the nose were not included in this report.

About the question of sulfonamides and what happens to the patient's immunity — theoretically, it could be bad from this standpoint: You could block this child from having infections and therefore block his building up his immunity. That is theroretically probable. If a child doesn't harbor any of these organisms, just as some children become immune to diphtheria by small doses of exposure, probably he may not build up immunity. I wondered about that. I couldn't find anything in the literature about it. My experience, which may be interpreted in various ways, is that after these children were on prophylaxis for 1-2 years their frequent respiratory infections did not recur the following winter. Whether they were more resistant or they had grown out of that phase, I don't know, but it didn't interfere with their immunity.

I think most people agree that sulfa doesn't affect the individual unless he is sensitive to it. It affects the organism only. On a small dose the patient presumably could develop a resistant strain. These children, after taking sulfa for a month, ought to relapse. They didn't. I think a small dose of sulfa will kill off a sulfa-sensitive organism. A virus or a sulfa-resistant organism will not be affected. That is as far as I have been able to get into the theoretical phases of it.

Dr. Eugene T. McEnery: I was glad to hear the way Dr. Mack handled the tonsil and adenoid situation because that always comes up, and his reaction is about the same as mine where he doesn't advocate it until the child is up around five, six or seven years. He said the

main trouble was in the adenoids. I don't know whether or not he is using x-ray treatment on his group of children to see whether they benefit, as far as respiratory infections, by the use of x-ray treatment to diminish or shrink down the adenoid or lymphatic tissue.

Dr. J. Keller Mack: That was a problem that I should have mentioned for completeness but I didn't want to go into it since I think it is a pretty sizable problem. It certainly works in some cases, as proven at Johns Hopkins Hospital, where there is a regrowth of adenoid tissue, causing blockage of the eustachian tube. These children who grow back lymphoid tissue very quickly after an adenoidectomy probably are the lymphoid type, if you want to call it that, and are going to have a regrowth of that lymphoid tissue probably as a means of protection to filter out bacteria.

Dr. Eugene T. McEnery: You can always throw in a plug for various industrial apparatuses on various respiratory infections. The other day a mother said to me — she had a large family of five children — she said, "You know, this year we have had very little occasion to call you. We have had very few colds." I said, "What is that due to?" She said, "You know, I was thinking about it. I wonder if this is the explanation: In the fall of the year we were fortunate in getting a dishwasher. With the use of the dishwasher, we really have not had many respiratory infections."

I began to think about that. Now that wasn't such a bad observation because when you see the way these dishwashers work and the heat of the water they generate there and how they wash the dishes, they certainly remove all bacteria on the dishes. It will be interesting to watch this over a period of years to see if it works out, and it may be a tip to you to see if it works out in your private practice because dishwashers are being used, since the old-time maid situation seems to be settled. There is no such animal.

I have enjoyed this paper and discussion very much. Is there any other discussion?

Member: At the Illinois Children's Hospital, we are caring for about ninety children with very severe orthopedic handicaps, and there is a practical recurrent bronchitis in the children who are under our care, so we have been using prophylactic doses of alphamin on muscular disuse atrophy and polio of the thorax and on a case of hypophonia for several years and we have found that we have had a very marked decrease in infections of this type. I would like to ask Dr. Mack whether he has had any experience with alphamin as a prophylactic agent.

Dr. J. Keller Mack: I think the institutional use of these drugs is not as good as when scattered around in the community because when you get into an institution, you are duplicating the army experience in which organisms develop resistance. But if you use them on selected cases, which you probably do, then I think you will get good results. I thought of using triple sulfonamides and decided that it wouldn't be quite as good as sulfamerazine because, for a small dose, I believe you get a more prolonged level with the latter. I always use triple sulfa for treatment.

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## ANTICOAGULANT THERAPY

The expense of performing a prothrombin test every day minimizes the economic advantage of Dicumarol, but, when a patient who has been receiving Dicumarol has been under observation for a time, it is frequently possible to lengthen the intervals between tests to as much as one week. However, extending the interval to more than 48 hours should not be attempted unless the physician has had extensive experience with the drug. It is evident that use of such a drug requires painstaking and meticulous observation of the patient and of the laboratory findings during the entire period of anticoagulant therapy. *Excerpt: The Administration of Anticoagulants, Charles D. Marple, M.D., San Francisco, Calif. Med., Aug., 1950.*

# Experiences with Neoplastic Diseases of the Thyroid Gland

**E. P. Coleman, M.D., and D. A. Bennett, M.D.**
**Canton**

There has been an increased awareness of the possibility of cancer in the thyroid gland, particularly following the work done by Cole, Slaughter, and Rossiter who have emphasized the incidence of malignancies in non-toxic nodular goiters, which in their series was over 17%. A careful appraisal of this material from both the clinical and pathological standpoint has been in the making for the past few years.

In the past, thyroid cancer has been recorded as being present in from 2 to 4% of the cases, but more recently it has been found that in toxic diffuse goiter, the incidence is less than 1% while in non-toxic adenomas it varies from 12 to 17%, and in solitary adenomas, especially in the young, it may rise to as high as 25%.

Our attention was called to this rather recently because of the fact that two of our patients who had non-toxic nodular goiters removed, and in whom the pathologist's diagnosis was "adenomatous goiter" with no evidence of malignancy found, have died from metastatic carcinoma of the thyroid. It seemed quite obvious that the failure to diagnose the cancer which was certainly present, was due in large part to the fact that the sections examined had not been taken from a portion of the gland which was malignant. Also it is possible that pathologists whose training was received in areas where goiter is uncommon, or more particularly those with European training only, may not be aware of some phases of thyroid pathology and therefore less alert to the diagnostic problems involved. We should bear in mind the statement made by Hertzler many years ago that in tumor of the thyroid there is sometimes a marked difference between clinical and pathologic malignancy.

As a result of this experience we have made a rather careful survey of the pathology in our own cases in the past two years. We have reviewed cases, where we had an opportunity of getting more than one section, some going back as far as ten years, and where in all of these cases examined, there was one or more nodules in the thyroid gland. This report is limited to 103 cases of non-toxic nodular goiters which have been removed surgically for various reasons. None of these were primarily toxic and malignancy had been suspected in only a few. In this group 21 true tumors were found, and 13 of these were malignant, essentially 13%. Interesting enough two more of these cases in addition to the first two quoted were first thought to be benign, but a more careful examination of the microscopic sections showed the presence of capsule and blood vessel invasion. Furthermore the slides examined were those from which the original diagnosis of non-malignant tumor had been made. Our diagnosis of malignancy in these specimens was confirmed by the opinions of two other pathologists, both of whom have had considerable experience in thyroid disease. Of the 13 patients in this group with malignant neoplasms, 6 have died of the original malignancy, and one has marked pulmonary metastases. The tumors consisted of the following types of pathology:—

Non-malignant tumors:
- 8 fetal adenomas

Malignant tumors: 13
- 4 papillary adenocarcinomas
- 1 Hurthle Cell carcinoma
- 2 adenocarcinomas
- 4 embryonal adenocarcinomas
- 2 carcinosarcomas

Four cases of Riedel's struma and three of Hashimoto's disease are not included in this report. For while they are clinically tumors of the thyroid, they are listed in most texts as being inflammatory conditions even though Hashimoto's disease is probably a lymphoid tumor.

For purposes of study we have included the so-called fetal adenomas in this series of cases as neoplasms. A careful examination of these adenomas should always be made because they

may be considered as precursors of malignancy or they may show evidence of being malignant adenomas. A fetal adenoma may be apparently benign in structure or it may also show evidence of mitotic activity, papillary structure formation, invasion of blood vessels, and capsule invasion. Eight of these cases appeared to be the benign type of fetal adenomas, while two adenocarcinomas appeared to have their origin in fetal adenomas. Several cases taken from this series are shown on the accompanying slides and quoted as examples.

Carcinoma of the thyroid may arise in an involuntary nodule or in a previously benign adenoma. Again, some carcinomas appear to begin primarily as a malignant process. Many times when the tumor is examined pathologically it is impossible to determine its origin with any degree of certainty but the more differentiated malignancies tend to resemble the nodular processes from which they originated.

Some primary thyroid carcinomas are surprisingly small. They may be too small to be palpated in the thyroid gland, and yet give rise to very large metastases in the cervical lymph nodes or in more distant parts of the body, such as the lungs, the bones, etc.

Of the individual cases reported, various types of pathology and symptoms were noted. One young man, aged 19 years, was examined because of three nodules in the left side of the neck. They were encapsulated, discrete, and not adherent to the adjacent structures. They were removed without difficulty and without opening into them in any way. The pathologist's report was "aberrant thyroid tissue". Since it is generally conceded that there is probably no such thing as lateral aberrant thyroids, but that they are always metastases in cervical lymph nodes from a primary carcinoma of the thyroid, a total lobectomy was done upon the left lobe and a small primary carcinoma was found. This tissue

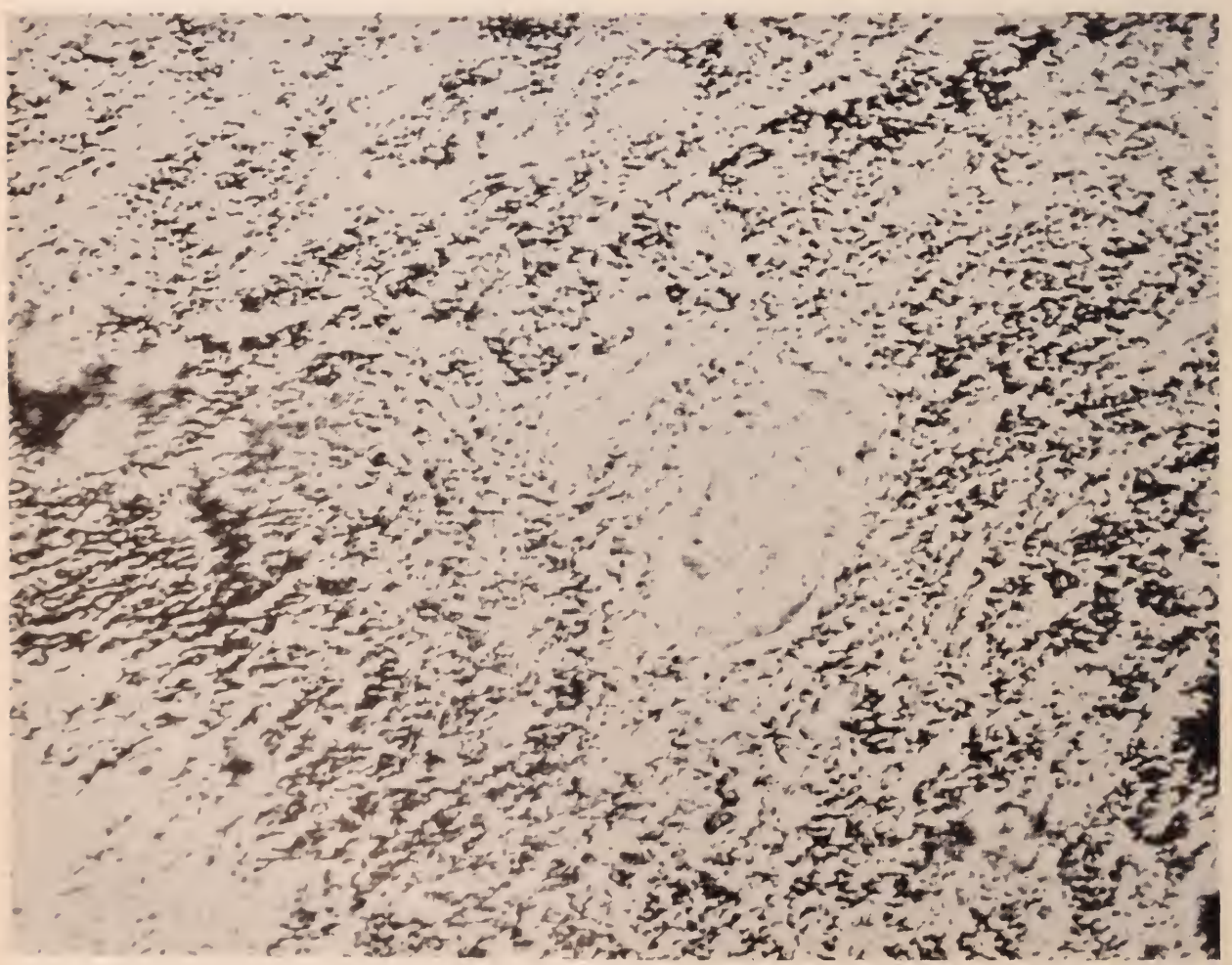


**Figure 1. Papillary adenocarcinoma, metastatic in lymph node.**

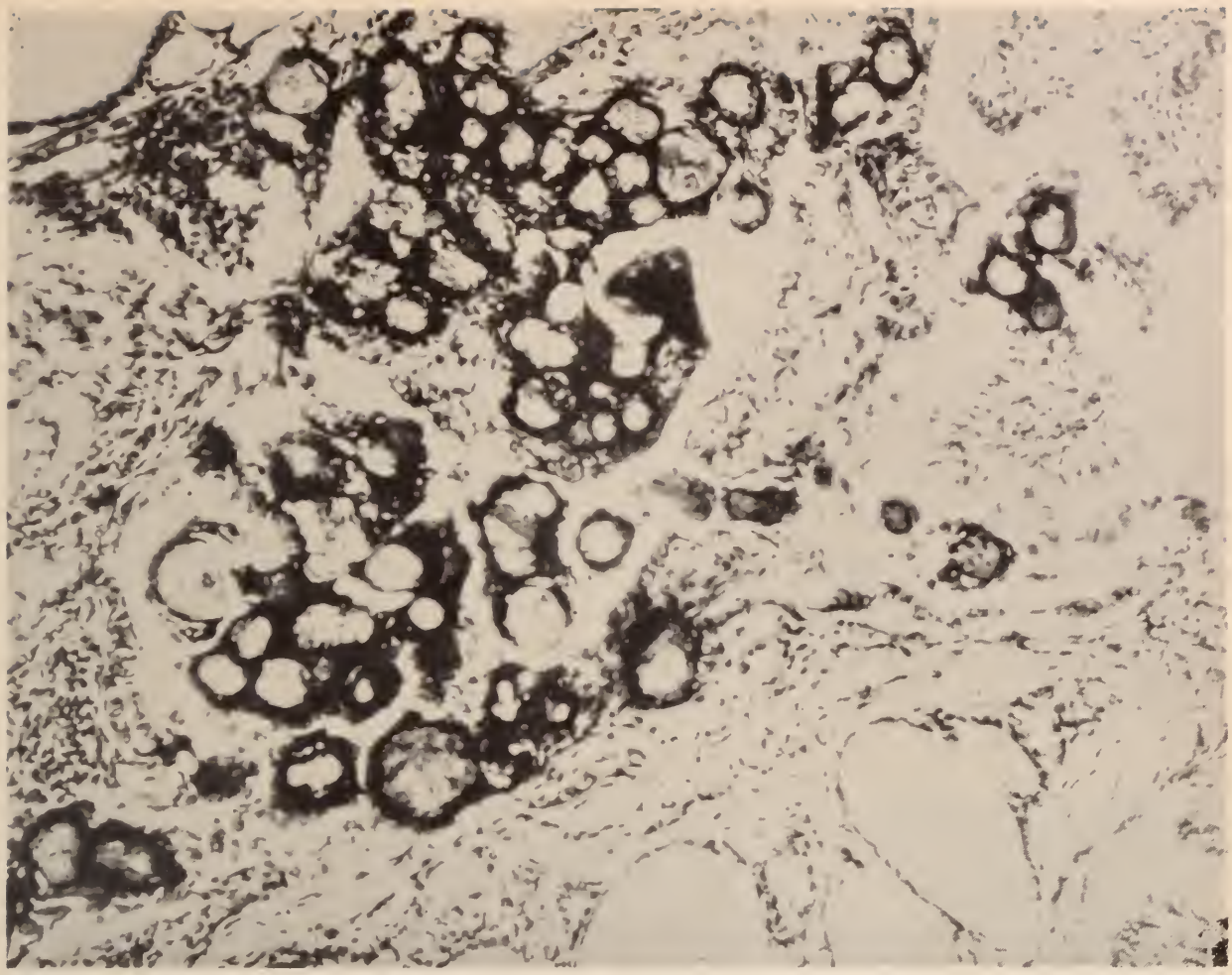


**Figure 2. Papillary adenocarcinoma.**

was found to be that of a papillary adenocarcinoma. Subsequently, re-examination of the cervical nodes resulted in the diagnosis of papillary adenocarcinoma from the same slides from which a diagnosis of benign tissue had been made.

Three of the fatal cases were found to have marked overgrowths that were microscopically papillary adenocarcinoma. All of these patients had recurrence which took place slowly. One of these died from suffocation, due to marked tracheal involvement. Tracheotomy was of only temporary relief. Another woman, quite elderly, developed pulmonary metastases four years after a thyroidectomy for papillary adenocarcinoma after having been in apparent excellent health. She has been referred recently to Dr. Clark of the University of Chicago for radioactive iodine therapy. The third case, also a young man, had a papillary adenocarcinoma of the thyroid gland removed by total lobectomy on the involved side. This patient died five years following surgery, from metastases to the cervical nodes and left iliac area. The metastatic growths were quite large, and yet no skeletal involvement could be found. The diagnosis was verified by autopsy.

Another variation of carcinoma was found in four cases of embryonal adenocarcinoma. These four cases each presented solitary nodules in the thyroid gland. Each solitary nodule was firm and had been steadily increasing in size. Carcinoma was diagnosed clinically in all four patients. The tumor was found to be composed of cords and interlacing trabeculae of large pale staining cells with little tendency to acinar formation. A total lobectomy was done in each of these cases and a subtotal lobectomy on the opposite side, which was apparently not involved. Three of these patients to date appear well with no evidence of recurrence, but they have not been

observed long enough postoperatively to judge their outcome.

We have had one case of the so-called "Hurthle Cell" type of neoplasm. The structure is that of a large eosinophil-celled tumor. This rather elderly man had a thyroid tumor of the right lobe, quite large, which was firm and growing slowly. On the left side the gland was soft, nodular, and had not enlarged during the past year. A bilateral subtotal removal was done and the tumor on the right side revealed the eosinoiphilic staining cells which seem characteristic of this quite rare type of thyroid malignancy. He has moved away and all contact has been lost so it is not known whether or not he has developed recurrence.

There has been a considerable difference of opinion as to whether true sarcoma occurs in the thyroid or if sarcoma-like cells are merely cancer cells of a high degree of malignancy. We have two such cases to report, one of which is typical of the fact often noted, of a malignant tumor appearing as a primary growth in what otherwise appears to have been normal thyroid tissue.

The first of these two, a woman aged 52, had a nodular tumor of the left lobe for many years. It was of slow growth but was finally removed for cosmetic reasons. At operation the tumor was left-sided and was removed rather completely. The right lobe was examined and was found to be small in size, soft, and normal in appearance, and being normal, was not disturbed. Microscopically the left lobe was a nodular colloid goiter. The patient remained well for two years when she noticed a small nodule in the upper pole of the right lobe. This doubled in size in a month and its removal was advised. For personal reasons this was postponed for another month during which time it quadrupled in size. Removal then gave gross evidence of a

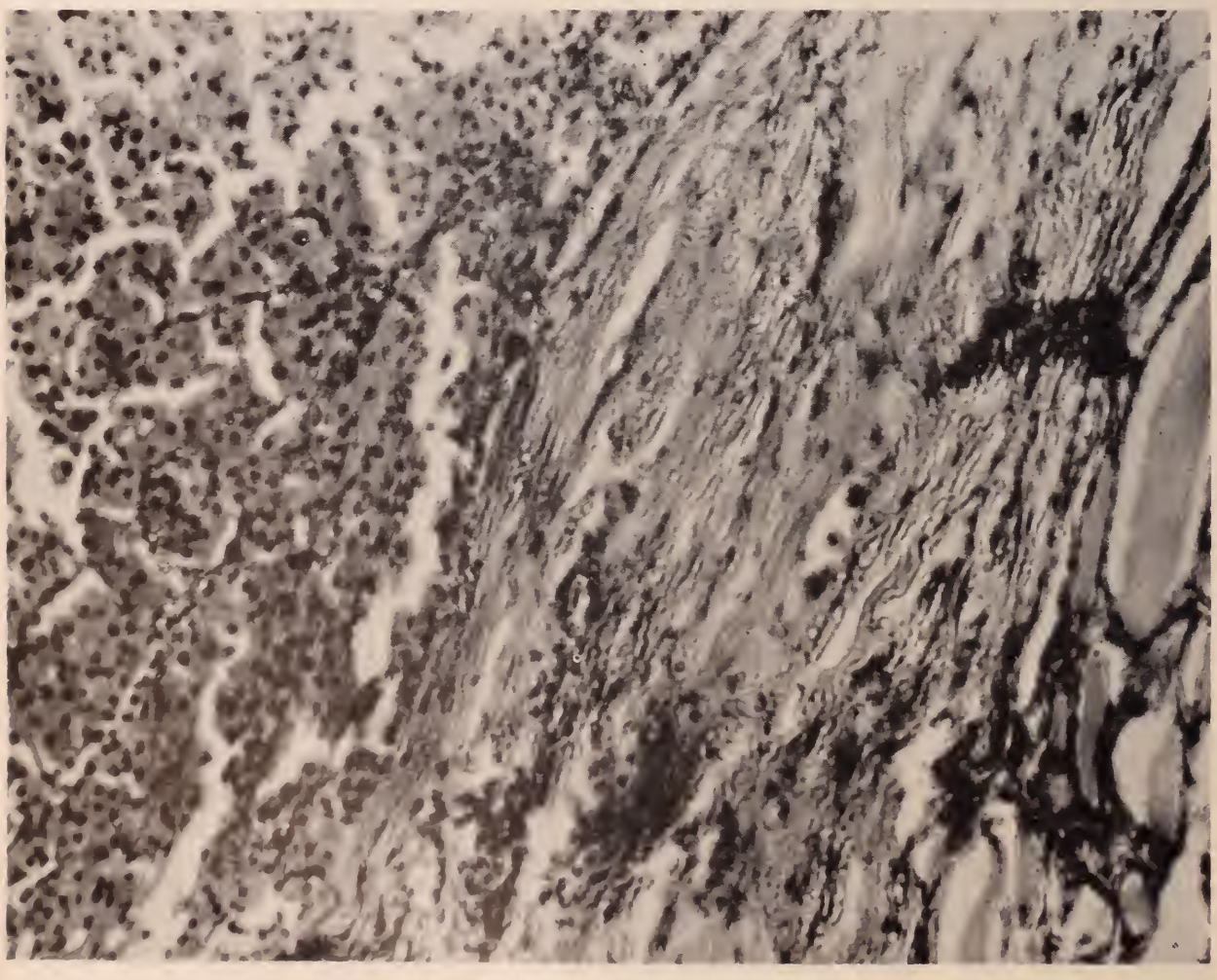


Figure 3. Hurthle Cell adenoma.

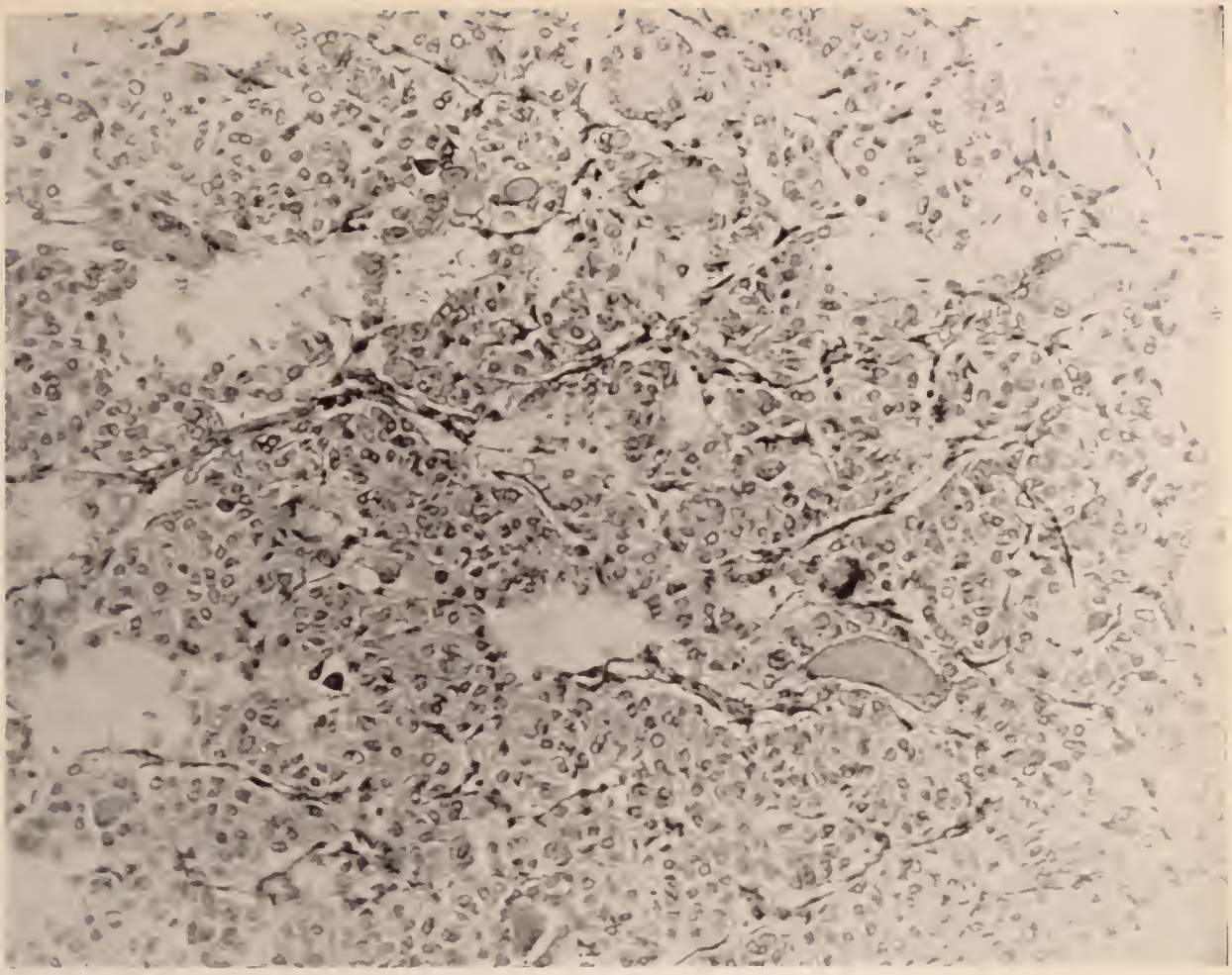


Figure 4. Embryonal adenocarcinoma.

malignant tumor, diffuse, soft, highly vascular, and infiltrating the adjacent tissues. The pathologist's report on this case stated that microscopically it was a sarcoma. Recurrence was rapid; it responded for awhile to x-ray therapy, but although distant metastases did not occur, local recurrence caused tracheal obstruction requiring tracheotomy. Ultimately in this case also, death from suffocation occurred, due to deeper tracheal involvement.

The second of these two cases was a young woman who presented herself for surgery with a large substernal goiter. She had known of this goiter for two years during which time she had had one child. The pregnancy and childbirth seemed to have no influence upon the growth of the tumor. That is, it did not, as many malignant tumors do, grow much more rapidly during pregnancy, and have a cessation of growth after pregnancy. At the time we saw her and at which time a thyroidectomy was performed, she was three months pregnant. Six months after the thyroidectomy she delivered a full term normal child and again, pregnancy did not seem to affect the tumor. At the time of operation the tumor was entirely in the thyroid capsule and extended down into the mediastinum. The right lobe was completely substernal and was removed with difficulty. The color of this tumor, that is the right lobe, was that of a pasty yellow, and it did not have the appearance of thyroid tissue. Its origin is a problem. The tumor was entirely within the thyroid capsule and yet grossly and microscopically appeared to be of non-thyroid tissue, the thyroid cells being completely replaced by the tumor cells. The specimen to be shown here has the appearance of a true sarcoma. Microscopically the structure appears to be a spindle cell sarcoma, perhaps the so-called carcinosarcoma. The patient is still alive three years following surgery with no evidence of recurrence

at this date. She has now had her third child, the second since the thyroidectomy.

These two sarcomas are excellent examples of the importance of distinguishing between pathologic and clinical malignancy. The first one was malignant microscopically. The cells which appeared to be of the sarcoma type were quite possibly epithelial in origin, but they were highly malignant both under the microscope as well as clinically. The rapid course and the fatal outcome fitted in with the microscopic appearance.

The second, which on the slide is a typical sarcoma and should be as highly malignant as it looks, is obviously a benign tumor on the basis of clinical findings even though it has been subjected to the stimulus of repeated pregnancies.

The two adenocarcinomas presented cancer cells arranged in sheets with capsule and blood vessel invasion. Both of these are living at present, without recurrence. However, both were removed while the lesions were quite recent in development and here as in cancer elsewhere, the time factor is perhaps of more importance than the extent of removal, providing that the removal is carefully and extensively done.

## CONCLUSION

An attempt to make a correct evaluation between epithelial hyperplasias, benign neoplasms, and malignant neoplasms has been made in the cases studied. By proper clinical study and interpretation of the morphologic findings in the thyroid gland the dividing line between benign and malignant neoplasms may be clarified. As a result of re-evaluating the microscopic findings in this series of nodular goiters and correlating these findings with the follow up on the patients clinically, we have found that at least in our experience it is advisable for the surgeon in charge of the case to keep in close personal contact with the microscopic findings on each thyroid tumor. We feel that while it



Figure 5. Carcino-sarcoma, probably a neurinoma.

is known that every nodular goiter may eventually become toxic, it is not so fully understood that it may also become malignant. We also believe that any tumor in the thyroid gland should be regarded as a potentially malignant tumor, and that its removal is usually justified.

We realize that a great many of the non-toxic nodular goiters which are soft, not growing, and which have been present for many years without symptoms, are not and probably will not become malignant. Their greatest danger is that of slowly becoming toxic and doing irreparable heart damage; but when the nodules become hard, or when a noticeable increase in size takes place, they should then be regarded as not only being potentially malignant but quite possibly as having already become malignant and removal should be much more extensive than is usually done.

Furthermore the presence of a solitary nodule in a young person carries a much higher likelihood of malignancy than any other type of thyroid tumor as shown in four of our cases. Some men place the incidence of malignancy in solitary nodules in the young individual as high as 25%.

The justification of thyroidectomy is brought out here when goiter is present and the possibility of malignancy is considered due to any of the previously mentioned signs. Two of our cases were diagnosed microscopically as being non-malignant, each with a fatal outcome due to recurrence. Two other cases which have been quoted were first diagnosed as benign neoplasms, but a more careful study of the same and other sections indicated the presence of carcinoma. This has made us feel that it is of great importance that the surgeon have a voice in selecting blocks of tissue from the thyroid gland for microscopic study and that he maintain an interest in microscopic pathology so as to share with the pathologist some of the responsibility in determining whether or not a tumor is malignant.

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## VITAMIN $B_{12}$

To the microbiologist, vitamin $B_{12}$ is one of the newest of the growth factors necessary for certain bacteria. To the biochemist, it appears to afford new information concerning nucleic acid synthesis. To the poultry scientist, it represents a further step in the elucidation of the nature of the factors necessary for the best hatchability of hens' eggs and the growth of chicks. To the physician, vitamin $B_{12}$ appears to be the long-sought antiperniciousanemia principle of liver, and to afford new insight concerning the pathogenesis of a disorder that has fascinated medical men since its original description by Thomas Addison a century ago. *Excerpt: Medical Progress: Vitamin $B_{12}$ and Pernicious Anemia, Maurice B. Strauss, M.D., Framingham, Mass., The New England J. of M., Aug. 3., 1950.*

# The Practical Aspects in the Diagnosis of Virus Infections by Current Laboratory Technics

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The laboratory procedures that aid in the diagnosis of virus diseases have advanced considerably over those of even ten years ago. These tests are for the most part still highly specialized and not easily rendered by the ordinary clinical laboratory. Special facilities and suitably trained, careful workers are required. The procedures commonly used generally consist either of attempts to effect a direct isolation and identification of the virus or of tests designed to reveal the presence of antiviral antibodies in the patient's blood.

It should be pointed out in the beginning that virus laboratory diagnostic service, when it is available, can usually offer diagnosis only in retrospect, since only in rare instances can positive laboratory findings be demonstrated during the patient's illness.

The most conclusive evidence of a virus infection consists of the demonstration of an agent in tissue or body fluids that will produce a transmissible disease in animals by the inoculation of bacteria free material and the subsequent identification of this agent by appropriate serologic tests. Such a procedure is, to say the least, tedious and expensive, and requires highly trained personnel and an extensive museum of viral agents, specific immune sera and immunized animals.

Once isolated, identification is attempted or accomplished by the determination of the various animals for which the virus is pathogenic, the routes by which it will infect, its tissue selectivity, the pathologic lesions produced (including the presence of inclusion bodies) and finally, the demonstration of a protection against the agent by antisera or vaccines of known virus agents.

The isolation and identification of viral and rickettsial agents must still be considered as research problems. Only occasionally will the isolation of the agent provide useful information that cannot otherwise be obtained more easily and cheaply by serologic methods now available for most of the common virus infections of man. Virus isolation studies, however, still hold an important place in the advancement of our still inadequate knowledge of virus diseases. These studies are important, for example, in the identification of new immunologically distinct strains of influenza that may appear and be unaffected by present vaccines, the discovery of new agents responsible for such diseases as the atypical pneumonias, central nervous system infections and gastrointestinal diseases of suspected virus origin, for which no agent has yet been discovered.

After identification of a virus, it is important to determine whether it was present in the body of the patient or the laboratory animal, as an incidental contaminant, or was actually the cause of the patient's illness. Strong reliance must often be placed on the results of a comparison of immunologic tests on the patient's sera taken during the acute phase and also during the convalescent stage of the disease, to demonstrate a rise in antibodies against the specific virus after the onset of clinical symptoms.

Serologic methods have provided the basis for our growing knowledge of virus diseases. The techniques are designed to demonstrate the appearance of specific antibodies to known viral and rickettsial agents during or following the course of an illness. Very early in the era of our knowledge of virus diseases, neutralizing anti-

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bodies, agglutinins and complement fixing antibodies were demonstrated in the sera of animals and humans convalescent from viral infections. More recently it was discovered that influenza virus was capable of agglutinating the red cells of humans, guinea pigs, and fowls. This property was subsequently shown to be present in other viruses, namely vaccinia, variola, mumps, Newcastle virus and other viruses of animals. Finally it was observed that this hemagglutinating power was inhibited by specific antisera for these viruses. This work has since become the basis for a new and valuable serologic test for these agents.

The most widely applicable of the serological techniques is the neutralization test based on the development of virus inactivating antibodies in blood as a result of infection with a specific virus. The serum to be tested is mixed with a suspected virus and then inoculated into a susceptible animal. A control test of the virus and a known negative serum is run in parallel and a comparison of the infectivity of the virus in the presence of the two sera is made on the basis of deaths or other specific signs of infection. The choice of the route of inoculation of the serum-virus mixture and the choice of the animal will vary for different viruses, but mice and the chick embryo are the most commonly used.

A knowledge of the time of the appearance of neutralizing antibodies in various virus infection is important in the proper interpretation of the neutralization test. These antibodies may appear as soon as the first week of illness in certain virus infections such as the equine encephalitides but they generally do not make their appearance in many virus infections until after 4 to 8 weeks. The test is therefore limited in most instances to the identification of a past infection rather than the current illness. Since neutralizing antibodies usually persist for years after infection, the test is valuable in epidemiological surveys to demonstrate previous inapparent or unrecognized infections in a population, but this fact must be considered in the diagnosis of any current illness and therefore it is highly important that a specimen of serum drawn early in the disease be shown to have been negative before a later positive result can be reliably interpreted as diagnostic for the specific illness. The test also provides the most conclusive basis for the identification of newly isolated viruses as well as the classification of immunological substrains within a broad group of related viruses.

Although the neutralization test has wider application than other diagnostic tests it is less desirable as a practical routine procedure for a number of reasons. Neutralizing antibodies tend to deteriorate rapidly unless sera are kept frozen. This usually limits the use of the test to specimens that can be brought immediately to the laboratory and kept under proper storage or can be shipped in dry ice. The test involves considerable expense per specimen due to the number of animals used. It involves the maintenance of a ready stock of virus agents and special precautions for the handling of highly infectious materials.

By comparison with the neutralization test the complement fixation test is a relatively new tool in the field of virus diagnosis. The development of this test as a diagnostic procedure has long been retarded due to the difficulty in preparing suitable antigens from tissue suspensions. The virus content of infected tissues is at best, very slight. Crude preparations contain substances interfering in the reaction, are frequently unstable and often became anticomplementary.

Within the last few years, considerable progress has been made in the concentration and purification of antigens for most of the viral and rickettsial agents. These antigens are still relatively crude and may vary in potency, specificity and stability. Little experience has been accumulated in their use in human infections and our knowledge of non-specific reactions in other diseases may still need to be modified. The test must still be carefully controlled and preferably confirmed by the neutralization test whenever possible. Despite these limitations, the complement fixation reaction provides the most available diagnostic tool that can be placed at the disposal of the physician through the clinical laboratory equipped to do the Wasserman test. When properly carried out, the complement fixation test is the method of choice because it usually permits diagnosis earlier than any other test, within 10 days to 2 weeks after onset. It is particularly valuable in the diagnosis of equine, mumps and St. Louis encephalitis, lymphocytic choriomeningitis, the psittacosis-lymphogranuloma and the rickettsial infections. Just as in the other serologic procedure, a rise in antibody titer must be demonstrated during the course of

the illness before a reliable diagnosis can be made.

Knowledge of certain virus infections of the respiratory tract has increased greatly within the short span of 15 years. Several distinct types of influenza virus have been isolated and widely studied. A number of immunologically related viruses of the psittacosis—lymphogranuloma group have been sharply delineated. The mumps virus has been isolated and propagated in chick embryos and extensively studied. The virus of lymphocytic choriomeningitis has been demonstrated in pneumonitis and influenza-like infections in man. These well defined specific infections, however, comprise the lesser part of the problem of virus infections of the respiratory tract. Within the last 10 years, primary atypical pneumonia has become the commonest form of pneumonia. Although numerous transmission studies in animals and man have indicated a virus as the responsible agent, the identity of the agent or agents has not been established. The presence of agglutinins to human red cells at low temperature and agglutinins against a variant streptococcus have been shown to be present in a variable percentage of these cases, but these tests offer little useful information. A number of viral and rickettsial agents can produce a disease similar to the common clinical syndrome of atypical pneumonia. These include the rickettsial agents of "Q" fever and the psittacosis-lymphogranuloma group. Reliable complement fixation tests are now available for most of these. Numerous agents of the psittacosis group have been isolated from human cases of virus pneumonia, presumably unassociated with avian reservoirs of infection. The agents of this group which also includes the virus of lymphogranuloma-venereum are tentatively classified in an intermediate position between the rickettsiae and the viruses. All of the agents produce tiny coccoid elementary bodies, stainable with basic dyes and visible under the microscope. All members of the group may be propagated on the chick embryo and infect mice by either the intranasal and intraperitoneal route, or both of them and usually always by the intracerebral route. On the basis of the complement fixation test they are antigenically related. The latest agent of the group isolated from cases of pneumonitis in Louisiana differs from the others by producing also a severe infection in guinea pigs.

Infection by agents of the psittacosis group is followed by the appearance of complement fixation antibodies in the blood, often as early as 4-8 days after onset but neutralizing antibodies appear irregularly and of low titer. They are therefore of little value in diagnosis. Since all agents of the group are immunologically related, a positive complement fixation with an antigen of any member of the group does not indicate which agent is involved since they all will react. For example, a positive test against the psittacosis antigen may mean the patient has or has had lymphogranuloma-venereum. It is therefore important that a definite rise in antibody titer be demonstrated during the course of the illness and that the presence of lymphogranuloma-venereum infection be ruled out. This permits a reasonably certain diagnosis of a virus infection with a member of the psittacosis group. The identification of the agent involved within the group requires the isolation of the virus from the sputum or lung tissue, and its subsequent identification by cross immunization tests in mice.

Diagnostic techniques for influenza have advanced more rapidly in recent years than those for any other virus infection of man. The development of the simple virus culture technique, using the chick embryo for growing the virus, the discovery of the red-cell agglutinating test as an indicator of the presence of the virus and the equally valuable discovery of the power of immune sera to inhibit this reaction all have resulted in a tremendous advancement of our knowledge of this virus disease. Unfortunately, the short duration of the disease and time required to secure diagnostic results still restricts the value of the diagnosis as it concerns the practicing physician. The principal use of the laboratory in influenza studies has been as a tool for the epidemiologist. With the appearance of an epidemic of an influenza-like respiratory disease, the laboratory attempts to identify the epidemic as influenza and further to identify the strain or strains of the virus involved. The same general methods applying to other viruses hold also for influenza. Attempt is made to isolate the virus from throat washings by the inoculation of developing eggs, mice and ferrets and to demonstrate rising antibody titer in the patient's acute and convalescent sera. This rise in titer may be demonstrated by the commonly used red-

cell agglutinin-inhibition test, the complement fixation or the neutralization tests. One essential difference in the interpretation of serologic reactions characterizes influenza. Almost all adults have circulating antibodies for the principal influenza types at the onset of infection. Between 6 and 10 days after the onset of illness, the antibody titer for the type of influenza virus causing the illness begins to rise and reaches a maximum in 2 or 3 weeks after which the level begins to decline. It is therefore absolutely necessary to have acute and convalescent phase serum specimens on which to make comparison.

*Neurotropic.*—There is a large group of neurotropic virus infections of man frequently encountered in epidemic form with well delineated seasonal and geographic distribution. Only those of importance in this country will be mentioned. Certain of these can now be grouped as arthropod-borne diseases, since the viruses have been isolated from mosquitoes, ticks, and mites, and convincing evidence exists to indicate that these invertebrate hosts may be vectors. The Eastern and Western strains of equine and St. Louis encephalitis viruses are present in various parts of this country. Lymphocytic choriomeningitis virus should be considered also, since its diagnosis and clinical manifestations follow the general pattern, although it is believed to be spread most commonly by excreta of rodents and has a more widespread occurrence with no sharp seasonal manifestation. Mumps encephalitis is not uncommon and is being recognized with greater frequency due to improved methods of diagnosis.

Most of the diseases in this group range in severity from a mild illness, with no indication of primary involvement of the central nervous system, to a severe syndrome characterized by stupor, tremors, convulsions, coma, and death. In diseases due to the St. Louis and equine viruses, the virus is rarely if ever found in blood or spinal fluid and therefore serologic methods alone are available for laboratory diagnosis, unless the disease is fatal, thus offering opportunity of isolating the virus from the central nervous system tissue. The lymphocytic choriomeningitis virus, on the other hand, is present in the blood and spinal fluid, and may be isolated with comparative ease. The mumps virus may also be isolated from spinal fluid in central nervous system infections.

In the midwest, the viruses of both Eastern and Western equine, as well as St. Louis lymphocytic and mumps are usually considered.

The first specimen of blood for diagnosis should be taken as soon as a neurotropic virus infection is suspected. The sooner the better. If taken early enough in infections with the equine viruses, this sample will fail to neutralize and in such instances, interpretation of a later positive is greatly facilitated. The next specimen may be taken between 2 and 3 weeks after onset, in the hope for an early diagnosis, but a negative result cannot be considered significant. A specimen taken 30 to 60 days after onset, preferably the longer interval, may sometimes be essential.

A large number of encephalitis cases still occur with which no known virus agents can be related, at the present time. In view of the possibility that these cases may represent infections, due to still unknown agents, the virus laboratory as one of its primary functions should make every attempt to isolate new agents from central nervous system tissues of such cases.

Poliomyelitis should be mentioned separately since there is as yet no practical immunologic tests which can be applied for purposes of clinical diagnosis. Virus isolation requires the use of monkeys and a correspondingly greater expense and effort in carrying out such studies. Isolation studies require from 2 to 5 weeks in the best equipped laboratory and therefore offer little value to the clinician.

In summary it should be stated that the generalizations that I have tried to make are based on the accumulated experience of a number of workers in the field. So much variation occurs in the behavior of viruses and their immunological reactions that few generalizations can be made without qualification. We can safely say that for reliable serological evidence of virus infection, blood must be taken within a few days after onset of symptoms and again after 2 or more weeks. Negative results on blood drawn earlier than 6 to 8 weeks after onset may often not be reliable. The detection of specific virus antibodies in a single specimen particularly if they are present in low titer, if of dubious diagnostic value since the serum of many persons may contain antibodies as the result of a previous infection that may or may not have been recog-

nized. If antibodies against a specific virus are absent early in the course of the disease and appear during the illness or in convalescence, it is reasonable to believe that this agent was the cause of the disease.

The proper submission of specimens to the laboratory plays an important part in determining the success or failure of virus diagnostic studies. At least 20 cc of blood should be drawn aseptically after the patient has fasted several hours. Serum should be removed from the clot within a short time if the specimen cannot be delivered promptly to the laboratory. All material such as throat washings, sputum, spinal fluid and tissue submitted for virus isolation studies must be frozen in dry ice while fresh and maintained in this state until they reach the laboratory.

Often a specimen of blood is sent to the laboratory with a request that a virus diagnosis be made, without any indication of what disease the patient might have, or of when the blood was taken in relation to the onset of symptoms. This practice as well as that of submitting blood specimens on all cases with vague symptoms of doubtful diagnosis, can seriously overburden the virus laboratory to the point where work of a more important nature is hindered.

The Illinois Department of Public Health provides limited facilities in the Chicago laboratory for making serological tests for most of the common viral and rickettsial infections. In special cases of public health importance or where an unusual frequency of cases of a suspected virus disease occurs, these facilities are concentrated on more extensive research studies to attempt an isolation and identification of the etiologic agent. Consultation with the laboratory should be made where isolation of the agent is desired.

Virus diagnostic service of a limited nature is also available in several hospitals in Chicago, and also through the United States Public Health Service laboratories in Bethesda, Md., Montgomery, Ala. and Chamblee, Ga.

## DISCUSSION

Dr. Goodbloom: I would like to ask if any virus has been isolated in diarrheas of the newborn, particularly those in which no bacterial agency has been discovered?

Dr. Devine: I would like to ask if there is anything of value in the question of measles encephalitis and any indication of virus disease?

Dr. Pilot: I'd like to ask if it is possible to get early diagnosis of rickettsial virus diseases with blood samples like we do for blood cultures? In one laboratory during the war we obtained excellent diagnostic work in rickettsial diseases. When patients were suspected of an acute rickettsial disease, we drew samples of blood and injected a guinea pig intraperitoneally. Temperature elevation was obtained and later smears of the spleen with the special stain for rickettsiae. In this way we were able to make early diagnosis in our soldiers, particularly in Texas. Later, the complement fixation test gave excellent results with sharp differences of Q fever and murine typhus, Bullis fever, etc. In bacteriological diagnosis, typhoid, streptococci and brucella organisms are obtained early in the blood culture. If we could get some febrile studies, specific reactions on egg cultures from blood samples, then earlier diagnosis of virus and rickettsiae diseases in the clinical patients would be possible.

Mr. Morrissey: There has been a considerable amount of work done on the infectious diarrheas of the newborn and on epidemic gastro-enteritis of suspected virus origin. Some of the results suggest a virus type agent as the cause. In one instance, the agent has been inoculated on the cornea of rabbits, producing typical lesions that could be serially transmitted in this manner. This work has not been duplicated in other investigations. An agent has also been transmitted thru nose and throat washings and fecal filtrates to human volunteers to produce a gastro-enteritis. Other workers have been able to transmit a virus type agent from epidemics of infant diarrhea to young calves. These reports have not been confirmed by other workers, and furthermore, the techniques involved do not lend themselves easily to practical diagnostic use.

The other question referred to diagnostic tests in measles encephalitis. We are interested, at present, in this particular problem, since we have had specimens from two recent deaths, from encephalitis, following shortly after an attack of measles. We have had only negative results from serological tests and virus isolation studies on these specimens. As far as we know, no virus has been demonstrated in measles encephalitis.

Regarding the question on rickettsia diagnosis, I did neglect to mention that animal inoculation does provide an early diagnostic test for rickettsial infections.

# The Role of the Radiologist in the Diagnosis of Bronchogenic Carcinoma

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In 1942 the U. S. census showed that carcinoma of the lung accounted for 4 per cent of all cancer deaths. In 1947 Rubin[1] stated that carcinoma of the lung occurred in 10 per cent of the cancer patients seen at Montefiore Hospital in New York. There is no doubt that the statistical incidence of carcinoma of the lung has increased in recent years. This is due to the fact that an increased life expectancy allows more people to reach the older age at which cancer of the lung occurs and to the fact that only recently surgical progress and better means of diagnosis have stimulated the interest of the profession in this disease.

Probably the most outstanding recent contribution to the diagnosis of bronchogenic carcinoma is the microscopic examination of bronchial secretions. This investigation is based on the presence of desquamated carcinoma cells in the expectoration or in the secretion collected at bronchoscopy. According to Papanicolaou[2] this method allows trained pathologists an accuracy of about 85 per cent in the diagnosis of carcinoma of the lung. Woolner and McDonald[3] reported several cases in which a cytological diagnosis of carcinoma of the lung was made before the appearance of any radiological signs. Such an accuracy would relegate radiological diagnosis of lung tumors to a secondary role if all patients were examined at an early stage of the disease. This however is not the case and since patients complaining of cough, hemoptysis, and weight loss may suffer from a number of diseases, a radiological study remains an essential part of the comprehensive examination which must be given these patients. Radiology however has definite limitations in the diagnosis of bronchogenic carcinoma and these limitations are not generally understood. The main limitations arise from the fact that in most cases roentgen rays will not show the tumor itself but only the changes which occur in the lung following partial or complete obstruction of a bronchus. This situation is very different from those encountered in the gastro-intestinal tract or in the skeleton where the tumor can be actually visualized and its characteristics studied in detail. About 75 per cent of lung carcinomas arise within the lumen of a large bronchus. This is unfortunate because the tumor may grow to a considerable size and possibly extend to the hilar glands before obstructing the air flow enough to give radiological signs. Such tumors may cause hemoptysis, cough, and weight loss but the chest film will show no significant pathology, (Figure 1, N). The clinician must be very alert in these cases. Such small tumors can be diagnosed by bronchoscopy, bronchography or cytologically much before the radiologists can detect them in a film of the chest. The clinician must keep in mind the possibility of carcinoma in spite of a negative chest film.

As the tumor continues to grow, it reaches a size where it almost obstructs the lumen of the bronchus. At this stage the peculiar mechanism described by Jackson comes into play. Since the diameter of the bronchi increases during inspiration, air slips by the tumor but in the expiratory phase, the diameter of the bronchi becomes smaller and air is trapped in the distal lung. This leads to obstuctive emphysema (Figure 1, E) and the emphysematous lung will appear in the roentgenogram better aerated than the remainder of the lung tissue. If the emphysematous portion is large enough, there may be displacement of the mediastinal structures toward the opposite side of the chest, depression of the diaphragm, widening of intercostal spaces on the affected side. Obstructive emphysema, however, is a phenomenon of short duration. Eventually the tumor grows large enough to

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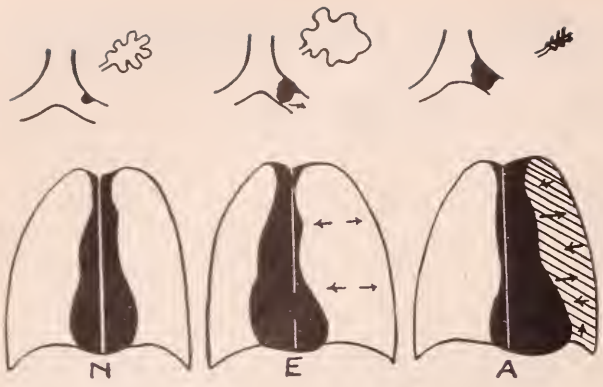



**Figure 1**

**N. Negative chest in the presence of a small tumor in the left main bronchus.**

**E. Emphysema of the left lung due to a tumor which almost obstructs the left main bronchus.**

**A. Atelectasis of the left lung due to a tumor which completely obstructs the left main bronchus.**

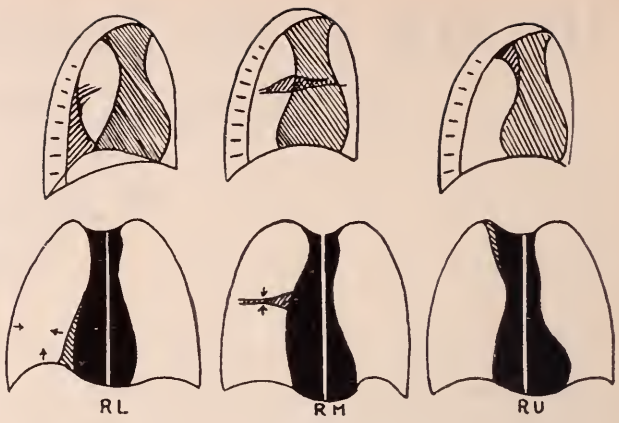



**Figure 2**

**RL. Atelectasis of the right lower lobe.**

**RM. Atelectasis of the right middle lobe.**

**RU. Atelectasis of the right upper lobe.**

obstruct the bronchus completely producing atelectasis of the distal lung (Figure 1, A).

Atelectasis is indeed the cardinal, if somewhat late, sign of bronchogenic carcinoma and it is important that one be familiar with its roentgen appearance in the various lobes (Figure 2). The clear cut appearance of atelectasis follows the anatomical shape and location of the various lobes and it is accompanied by changes due to the decreased lung volume. The mediastinal shadows are displaced toward the affected side and show a pendular movement during fluoroscopy. The intercostal spaces are narrowed, the diaphragm elevated on the affected side. These changes are more evident in atelectasis of the large lower lobes than in atelectasis of the smaller middle or upper lobes. It should be remembered that the shadow of an atelectatic lobe may be quite large but this is no indication of the size of the tumor. The tumor itself needs to be only large enough to obstruct the bronchus. In addition to the changes due to atelectasis, later in the disease, the radiologist may observe rib erosion, especially in the upper lobe tumors which give rise to the Horner's syndrome and are prone to invade the thoracic cage.

About 25 per cent of lung carcinomas arise in the periphery of the lung. These tumors may be bronchogenic or originate from the alveolar epithelium. The peripheral bronchogenic tumors presents essentially the same roentgen characteristics as those arising in the large bronchi, producing localized emphysema (Figure 3, E) and later atelectasis (Figure 3, AT) usually wedge shaped with the apex directed centrally.

Infection of the atelectatic lung plays a great role in many cases and lung abscesses of carcinomatous origin are frequent enough (Figure 3, AB) that one should always suspect carcinoma when single or multiple abscess cavities are seen. These abscesses usually have thicker and more irregular walls than the common pyogenic abscesses and respond poorly to medical and surgical treatment.

Bronchogenic carcinoma in the hilar region can cause sufficient pressure on the vessels to produce venous engorgement (Figure 4, V). This becomes apparent in the radiograph only when such tumors grow more outside than inside of the bronchial lumen so that venous engorgement precedes atelectasis.

Some tumors invade the lymphatic pathways in a retrograde fashion. If this is not masked by atelectasis, the lung will assume a reticular appearance (Figure 4, L).

At times it is difficult to distinguish between a bronchogenic carcinoma of a large bronchus and a centrally located mass of other origin (Figure 4, C). In a general way, however, large hilar masses bordered by clear lung are rarely due to bronchogenic carcinoma. Lateral views will localize such masses and it will be found that most of the anterior masses belong to the thymus, dermoid, and vascular groups. The middle ones originate from the hilar glands and the posterior masses from the pleura, nervous system, or the

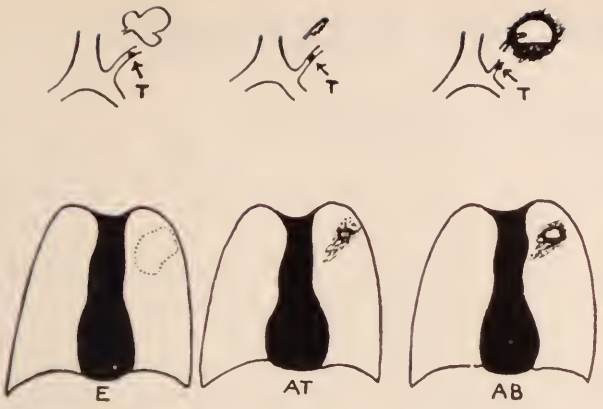



**Figure 3**

**E. Localized emphysema due to partial obstruction of a small bronchus.**

**AT. Localized atelectasis due to complete obstruction of a small bronchus.**

**AB. Abscess following infection of the atelectatic area.**

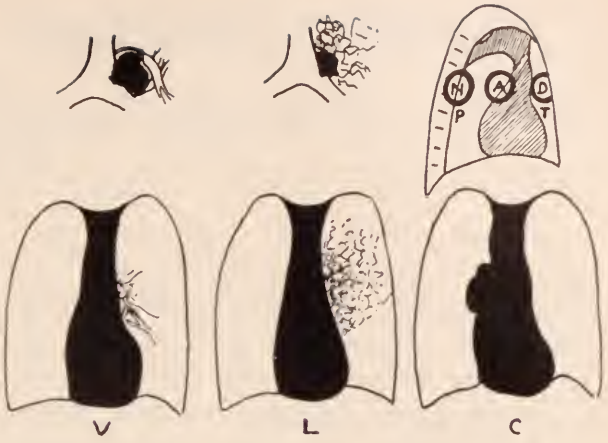



**Figure 4**

**V. Venous engorgement due to a tumor in the hilar region.**

**L. Retrograde malignant lymphatic involvement of the lung parenchyma.**

**C. Centrally located masses due to neurogenic or pleural tumors (NP), adenopathy (A), or to dermoid or thymic tumors (DT).**

aorta. Bilateral paramediastinal masses also tend to exclude bronchogenic carcinoma.

This brief review of the radiologic aspects of bronchogenic carcinoma shows that the radiologist can suspect such a tumor only after it has reached a fairly large size. For tumors arising in the large main bronchi, this is rather late in the course of the disease.

It should be realized that the diagnosis of chest diseases is a matter of team work. The role of the radiologist on this team is an important one but should not be over-emphasized. This may be illustrated by the following examples:

A. A patient presents himself complaining of cough, weight loss, hemoptysis. He may have a number of disease. The radiologist can be of great help if he can establish a diagnosis other than carcinoma of the lung.

B. The chest film discloses localized emphysema or atelectasis. The radiologist suggests a diagnosis of carcinoma and localizes the obstructed bronchus. This is the usual, rather late case, in which surgical results are not good.

C. A patient complaining of cough, weight loss, hemoptysis presents a normal chest film. In this case it is essential that the clinician be alert and ask for cytological, bronchoscopic and bronchographic study. These examinations may disclose an early, non-obstructing bronchogenic carcinoma which will respond well to surgery. A negative chest film thus becomes the most important contribution that a radiologist can make toward the early diagnosis of carcinoma of the lung.

D. A patient who complains of weight loss, cough, hemoptysis and has a negative chest film may also be cytologically, bronchoscopically and bronchographically negative. In this case, one should not rely only on repeated x-ray examinations but also repeat cytological studies of the sputum. If this patient has a carcinoma, the cytological study is likely to become positive before the bronchus is obstructed enough to give radiological signs.

These examples show that although the radiologist is an essential component of a diagnostic chest team, the burden of early diagnosis of carcinoma of the lung should not rest upon him. This burden rests principally upon the men of clinical medicine who must be constantly aware of this frequent disease. If a diagnosis of carcinoma of the lung can be made before the appearance of radiological signs, a negative chest film will be the best assurance of a good surgical result.

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# Caustic Strictures of the Esophagus

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The full impact of the significance of the tragedy which strikes a child who has swallowed a caustic is rarely realized at the time of the accident. Irreversible changes occur due to the burn which damage the smooth mucosal surface of the esophagus. Scar tissue which replaces the mucosa in the denuded areas slowly but continually contracts for the duration of the patient's life to produce either a rapid cicatricial atresia of the esophagus or a slowly progressing stenosis. The fact that such a life-time process can develop from a single swallow of lye is not generally appreciated, and the untreated patient is not fully aware of the significance of the slight but progressively increasing dysphagia.

This paper, therefore, is presented to review the subject of caustic strictures of the esophagus and to point out the need for early continued active treatment. A series of 96 consecutive cases is presented to stress the etiology, pathology, and the various forms of treatment used in the management of the acute burn and the well-developed strictures. Special emphasis is placed on the fact that a patient who has swallowed a caustic must be observed for a period of years to insure a patent esophagus. A series of tight esophageal strictures may be found in a patient years after the ingestion of a caustic. Occasional esophageal dilatations at regular intervals after the accident will prevent this complication in later life.

This study is based on a series of 96 patients who have swallowed various types of caustics. It includes all such patients examined and treated in the Broncho-Esophagological Clinics of The Children's Memorial Hospital, St. Luke's Hospital, and The Research and Educational Hospitals of The University of Illinois College of Medicine, Chicago, during the 13 year period from 1936 through 1948. (Table 1.)

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## ETIOLOGY

*Type of Caustic.* Lye, with which is included the commercially packaged Chlorox, Drano, Saniflush, etc., was the predominating caustic encountered in this group; in 74, or 77%, of the cases this caustic was swallowed. Nine, or approximately 9.5%, of the patients had swallowed ammonia. Five, or 5%, had swallowed an acid such as sulphuric acid, nitric acid or muriatic acid used in soldering. Eight, or 8.5%, had swallowed iodine, carbolic acid, lysol or lactic acid.

*Age at the Time of the Accident.* This significant etiologic factor divides the patients into four groups. Fifty-five, or 57.3%, of the patients swallowed the caustic before they were 5 years of age; seven, or 7.3%, between 5 and 10 years of age; nine, or 9.4%, between 11 and 20 years of age; and twenty-five, or 26%, were adults over 20 years of age.

In correlating the two etiologic points of type of caustic and age at time of accident, the reason the patients may be divided into these four principal groups becomes evident. The first group (55 cases), by far the largest group, is composed of children who have ingested the caustic by accident. The caustic was almost always swallowed by the child because it had been placed in a container usually used for food — a cup, a glass, a soda pop bottle or a Coca-cola bottle. However, "medicine cabinet" accidents also played a significant role in this group. Iodine or lysol mistaken for cough mixtures were given to children, or the children reached into a medicine cabinet for one of the bottles containing these solutions and swallowed its contents. Undiluted lactic acid used for the preparation of lactic acid milk was given by mistake to one infant by his mother; the lactic acid and some cod liver oil had been dispensed in almost identical bottles, and 10 drops of the former had been given directly to the infant instead of 10 drops of cod liver oil. In the second group (7 cases),

TABLE 1

| | Total Number | Sex M | Sex F | Race W | Race C | Type of Caustic: Lye* | Lysol | Ammonia | Nitric or Sulphuric Acid | Iodine | Lactic Acid |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Group I 0-5 yrs. | 55 | 30 | 25 | 42 | 13 | 44 | 4 | 3 | 2 | 1 | 1 |
| Group II 6-10 yrs. | 7 | 6 | 1 | 4 | 3 | 6 | | | 1 | | |
| Group III 11-20 yrs. | 9 | 0 | 9 | 9 | 0 | 9 | | | | | |
| Group IV over 20 yrs. | 25 | 9 | 16 | 21 | 4 | 15 | 2 | 6 | 2 | | |
| Total | 96 | 45 | 51 | 76 | 20 | 74 | 6 | 9 | 5 | 1 | 1 |

*Includes Drano, Chlorox, Saniflush, etc.

there were 6 boys and 1 girl between the ages of 5 and 10 years at the time of accident. They had swallowed lye (6 eases) on a "dare" and acid (1 ease) because it was found in a Coca-eola bottle used for soldering solution in workshop.

The third group of patients (9 cases) is found to consist of young girls who attempted, dramatically, to swallow a poison because of disappointment in a love affair or because of some problem at home which had ended with a severe disciplinary measure. Lye was the caustic used in each case.

The fourth group consisted almost entirely of adults who had developed well reeognized psychopathic personalities with periods of depression during whieh they made feeble attempts at suieide by swallowing a small quantity of lye, lysol, ammonia or aeid. During severe depressions such patients may swallow a large quantity of caustie from whieh they may die in a few days of chemical mediastinitis or peritonitis. Three cases of aecidental caustic ingestion are listed in this group.

*The sex incidence* of the four groups is significant. In the first group of 55 children under 5 years of age at the time of ingestion of the caustic there were 30 boys and 25 girls. As mentioned, of the 7 children 5 to 10 years of age, 6 were boys. The 9 patients who swallowed causties between the ages of 11 and 20 years were all female. Of the 25 patients over 20 years of age there were 9 males and 16 females. It is interesting that in the entire group of 96 patients, there were 45 males and 51 females.

*The race incidence* shows a total of 76 white and 20 negro patients. Forty-two of the 55 children of Group I were white; 13 were negro. In Group II, 4 were white, 3 negro. In Group III, all 9 were white. In Group IV, 21 of the 25 were white, 4 negro.

## PATHOLOGY

*The Acute Burn.* Thirty-one, or 32%, of the 96 patients were seen within the first 2 weeks of the ingestion of the eaustic and are considered as having been seen during the acute stage of the burn. Following the ingestion of the eaustic, the faee, tongue, pharynx, larynx, esophagus, stomach and duodenum were found involved in varying degrees. Children who swallowed only a small amount of the eaustic often had extensive burns around the face, over the chest, and on the hands. The lips, tongue, buecal mucosa, hard and soft palates, and pharyngeal mucosa were swollen, uleerated and covered with a white exudate which subsequently desquamated to leave patchy uleerated areas throughout the mouth. Esophagitis, periesophagitis and mediastinitis were frequently demonstrable on chest x-ray, apparent by the wide mediastinal shadow and peribronehial infiltration. Aeute laryngitis with laryngeal edema was present in the more severe burns; two children required tracheotomy during the aeute stage. Gastritis was so severe in three patients that pyloric stenosis developed whieh required a jejunostomy in two of the three and a gastroenterostomy in the third patient. In one patient, an adult who succeeded in suieidal attempt, a chemical mediastinitis and peritonitis developed from perforation of the esophagus and

stomach by the erosion of the acid he had ingested.

The acute stage generally lasts 1 to 2 weeks during which the patient is seriously ill and unable to swallow even his own saliva. Improvement in the swallowing function is seen 1 to 2 weeks after the accident, and often a complete return of full function follows in 3 to 4 weeks. Later, however, as healing progresses there is a return of dysphagia, often so gradual that it is evident only in changes in the patient's eating habits. He gradually learns to eat fewer solids, washes down each mouthful of food with water or milk, and learns to gag himself to dislodge food which becomes stuck in the stricture. It may be 5 months or 5 years before the stenosis becomes severe enough to require surgical intervention, but once a patient has swallowed lye some type of treatment will eventually have to be instituted to keep the food passage open. Tight, benign esophageal strictures of adults not infrequently are due to lye swallowed during childhood, producing obstructive symptoms only years later.

*Chronic Strictures.* Sixty-five, or 68%, of the patients in this series were seen because esophageal stenosis had developed which necessitated re-establishment of some method of feeding, or because of strictures or atresia of the esophagus which required dilatation. In some, complete esophageal atresia had developed as soon as a month after ingestion of the caustic. In four patients symptoms of dysphagia, which had progressed insidiously, became severe enough to require treatment from 25 to 60 years after the ingestion of the caustic.

The chronic lye stricture of the esophagus is usually extensive, with multiple strictures throughout the course of the esophagus; some are thin shelves of tissue and others long cylindrical bands of scar tissue. Complete atresia not infrequently occurs. The mucosa between strictures is usually very thin and it is in these areas that perforations most often occur rather than in the strictures themselves.

The most common sites of the chronic strictures are of special significance. In this series of patients the most severe strictures were found at the cricopharyngeus and at the cardia. It is probable that this due to the hesitation, and consequently greater burn, of the caustic above these physiologic sphincters.

Associated systemic disease was commonly found in the patients with chronic stenoses or atresias. In some patients gradually progressive stenosis was associated with severe starvation states, dehydration, avitaminosis and anemia. Two patients were found to have pulmonary tuberculosis. Dental caries is a prominent associated finding, especially in the children. Physical developmental retardation was prominent; children of 10 to 15 years of age who had swallowed a caustic in infancy, who had had gastrostomies for years because of complete esophageal atresia, appeared physically to be three to five years younger than their actual ages.

## DIAGNOSIS

The diagnosis of a caustic burn of the esophagus is usually apparent from the history alone. If a patient has ingested a caustic the probability of a burn severe enough to cause a stricture is very great. The caustic burns the mouth so severely that the patient attempts to get rid of it by every means of emptying the mouth, including swallowing. Therefore, it must be assumed that a burn sufficient to produce changes in the mouth has also produced changes in the esophagus, and treatment must be directed toward that eventuality. Fluoroscopic examinations with radio-opaque media and esophagoscopy during the acute stage are contraindicated. After the acute burn has subsided, or in an attempt to detect the presence or location of a stricture at a later date, fluoroscopic and radiographic technics are of first importance. If an atresia of the esophagus exists or if dysphagia is very marked, lipiodol or other radio-opaque oils should be substituted for barium to avoid aspiration of barium into the tracheobronchial tree. In cases of complete esophageal atresia retrograde studies give information concerning the cardiac end of the esophagus. The opaque medium is introduced through the gastrostomy tube, and by placing the patient in the Trendellenberg position the barium may be observed to flow upward to outline the lower esophagus.

Esophagoscopic examination is the final diagnostic procedure and follows the roentgenographic studies. As mentioned, it is contraindicated in the acute burn because of the danger of perforation and because it can add little to what is already known—namely, that an acute

burn has occurred and severe edema is present. Strictures form later with healing and cannot be detected early.

## TREATMENT

Any discussion of the treatment of lye strictures should begin with prophylaxis. Laws regarding adequate "poison" labels on lye containers exist, but they are not enforced. Lye, Chlorox, ammonia, and similar caustics should not be in the home unless absolutely necessary for some specific purpose, and then the excess should be properly discarded or placed where it is inaccessible to children. Most important, lye should never be placed in a container ordinarily used for food, since this is the most common cause of this accident.

The immediate treatment of an acute lye burn consists of the weak neutralization of the alkali by orange juice or very weak vinegar. Stronger acid solutions are caustics in themselves and should be avoided. Sedatives are indicated because of pain; symptoms of shock should be treated as they occur. Attempts to wash the stomach are dangerous because of possible perforation. Burned areas of the lips, chin and hands may be covered with olive oil and the mouth kept as clean as possible with mild antiseptic. It is generally necessary to give fluids intravenously, and a gastrostomy may have to be considered soon after the ingestion of the caustic if the burn is unusually severe.

Two courses of treatment now present themselves. Formerly dilatation of the esophagus was begun only after the acute inflammatory reaction had subsided; dilatation was then performed by esophagoscopy, retrograde technics or by olive-tipped bougies passed over a string. At present active dilatation is begun 24 to 48 hours after ingestion of the caustic, using soft rubber smooth-tipped catheter-like bougies filled with mercury. Graduated sizes from 16F to 30F for children or up to 48F for adults are inserted into the mouth, well lubricated. They advance to the stomach by their own weight. Two or three bougies are used once daily, gradually increasing the size during the first two weeks. Dilatations are then spaced twice a week for a month, then once a week for another month. Subsequent dilatations are continued at monthly intervals for a year and then the period between dilatations is increased. It is of utmost importance that the patient continue with this regime. The tragedy in most cases of esophageal strictures is that the family, and often the physician, are not aware that the return of normal or almost normal swallowing occurs after the acute edema associated with the original burn subsides. Treatment must be continued during this period of relative lack of symptoms if stricture formation is to be avoided.

Treatment of chronic caustic strictures of the esophagus presents a never-ending problem. The simplest strictures are the solitary webs that can be opened with a few esophageal dilatations to permit normal swallowing function. Such strictures should be re-examined at intervals of one to three years and dilated to avoid recurrence. Olive-tipped bougies passed over a previously swallowed string are frequently used and are an adequate means of dilating multiple strictures. "Courses" of treatment may be given over short intervals, followed by a rest period when an adequate lumen has been established.

In cases of multiple strictures of the esophagus that have necessitated gastrostomy, a swallowed string may be recovered through the gastrostomy opening. Dilatation is then most easily performed by retrograde bouginage, the bougies being attached to the gastrostomy end of the string and drawn up from below.

Twenty-seven of the patients who were seen in the chronic stage of their disease had complete atresia of the esophagus at the time of hospitalization. Obstruction was complete even to their inability to swallow their saliva. Esophagoscopic bouginage was employed both from above and from below by means of the gastrostomy opening. The procedures were controlled under biplane fluoroscopy in most instances. In five patients a Barretto needle was employed to perforate the atresic stricture after biplane fluoroscopy had demonstrated the esophageal and gastroscopic scopes to be in perfect alignment. In two patients the esophageal lumen could not be re-established and subcutaneous skin-flap tubes were constructed by Dr. John Reynolds to connect an upper esophagotomy with the gastrostomy opening.

There have been three deaths in this series. One, the infant who had been given lactic acid by accident, died after perforation of the esophagus which occurred during dilatation. This accident occurred before the present chemotherapy and antibiotics were available. This perfora-

tion developed during dilatation in the chronic stage of the stricture, not during the acute stage. The infant was first referred after the stricture had fully formed and obstruction was almost complete. The second death was due to aspiration pneumonia. A tracheoesophageal fistula developed during the course of treatment of this 8-year-old girl. Development of the fistula did not bear any direct relationship to any specific esophageal dilatation, but it is possible that the fistula was due to perforation at the time of a treatment. The third death occurred in a man who had swallowed a large quantity of "boiler fluid", a combination of sulphuric acid and hydrochloric acid. He had multiple esophageal strictures, marked destruction of the stomach and duodenum, and eventually required a jejunostomy for feeding purposes after a gastrostomy proved to be unsuccessful. Death was due to gradual inanition and had no relation to esophageal instrumentation.

Fifty-seven or 60%, of this series of patients required gastrostomy or jejunostomy during their course of treatment. The gastrostomy initially served for feeding purposes and subsequently for retrograde dilatation. The course of treatment always seemed more rapid once the retrograde technic was instituted. In multiple tight strictures this technic is considered safer than dilatation from above.

The most important single fact demonstrated by a review of this series of 96 patients is that once the accident of caustic ingestion has occurred, continuous and repeated treatment is necessary to avoid stricture development. If the stricture is successfully treated and normal swallowing function is restored, occasional treatment must be administered to prevent recurrence of stenosis. Multiple gastrostomies were required in 6 patients. Four were children whose parents failed to keep appointments after dilatation had proceeded satisfactorily, swallowing function had been restored, and the original gastrostomy closed. Two were adults who had swallowed the caustic in unsuccessful suicide attempts. They were uncooperative through all treatment. One of the two died following an attempted esophageal resection.

Resection of the strictured portion of the esophagus and anastamosis of the stomach to the residual proximal esophagus has recently been advocated with considerable success. In solitary strictures near the cardia this has considerable value. However, strictures usually are multiple, and often the most resistant stricture lies at the level of the cricopharyngeus, making it almost impossible to resect all the pathology. Consequently, it has been necessary to continue dilatations in some patients who have been resected, either dilating the high stricture or the stricture that has developed at the point of anastamosis.

## SUMMARY

An analysis of 96 consecutive cases of caustic burn of the esophagus has been presented. An analysis of the types of caustic agent ingested, the age groups, sex, and race incidence is given in Table I. Most cases occur in children and are accidental, the caustic being placed in a container ordinarily used for food or drink — a glass, cup, Coca-cola bottle, etc. Acute burns constituted approximately 1/3 of the patients while the remaining 2/3 were first examined only after multiple strictures had developed. Most significant is the recent change in the management of the acute burn, beginning dilatation within 24 hours of the accident by means of soft rubber mercury-filled bougies. No strictures have developed in the patients so treated during the three years this treament has been used, and no complications such as esophageal perforation have developed. Once a caustic has been swallowed, dilatation or some form of esophageal examination must be continued throughout the life of the patient at increasing intervals. Failure to continue management when swallowing function is restored, either initially or in later years, results in cicatricial contracture of the severest type for which gastrostomy, multiple dilatations, or esophageal resection may have to be done.

# Clinical Implications of Growth

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*Dr. J. B. Richmond Associate Professor of Pediatrics*: I am grateful for this opportunity of discussing with the members of the Department of Medicine some of the problems of the clinical implications of growth. Since both of our specialties are "medical" in character, we search for distinguishing features. Growth is the major factor which distinguishes our patient from the adult medical patient. While the whole subject of growth is too vast to be considered in any comprehensive fashion during one brief seminar, we can discuss some clinical conclusions which are based on specific changes with which growth is associated. I might say parenthetically that in pediatric departments today, as much as fifty percent of teaching time is devoted to considerations of growth and development in some form or other.

To orient ourselves, it is well to review for a moment Scammon's classic representation of the growth of the body and some of its constituent tissues (Figure 1). These curves demonstrate that the young organism is not a "miniature adult" but shows both qualitative and quantitative differences from the mature organism. The rate of growth of the body as a whole is most rapid in infancy and during adolescence. The importance of an adequate dietary intake of all necessary food factors during infancy has been well appreciated for some years. It has been demonstrated, for instance, that the clinical appearance of scurvy or rickets during infancy, as a result of vitamin C and D deficiency respectively, is enhanced by the rapid growth which characterizes this period of life. Johnston has recently emphasized that inadequate vitamin D and/or calcium intakes concomitant with rapid growth may produce clinical manifestations such as slipped epiphysis and epiphysitis during adolescence. Some unreported studies of ours indicate that subclinical vitamin deficiencies during adolescence may be considerably more frequent than is generally appreciated. The increased cellular activity associated with rapid growth makes metabolic demands which should be respected. Recent studies by Albright suggest, as a matter of fact, that inadequate pro-

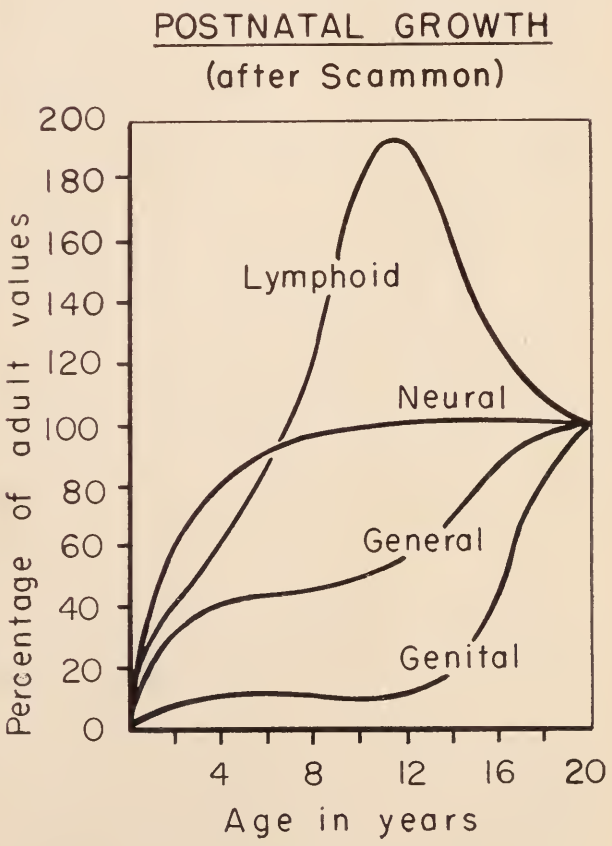



**Figure 1**

tein intake may have a definite bearing on the extent of damage caused by vitamin deficiencies.

Further inspection of these curves reveals that central nervous system growth is rapid and almost complete in early life. Although the total number of neurons is present at birth, recent work has indicated that synapses have not necessarily entirely established themselves. This may, in part, explain the adaptability of the central nervous system in early life. Lymphoid tissue, it may be noted, undergoes rapid growth in early life and attains a total mass greater than that ultimately observed in the adult. I would like to mention only one facet of this observation: its relation to tonsillectomy. Tonsils are physiologically large during childhood; size alone should never become an indication for tonsillectomy unless specific symptoms result. It is significant that several years ago the Child Health Association conducted a survey in which a group of children were examined by several physicians. Recommendations for tonsillectomy progressively increased as the number of examining physicians increased.

Disease processes may influence growth generally or locally. Dean Brodie and Dr. Engel of the Department of Orthodontia have been involved in quantitative studies of cranio-facial growth for some years. For the past two years their techniques have been applied to the study of children with rheumatoid arthritis. In approximately 20 percent of our cases, we have observed significant retardations of mandibular growth resulting, to some degree, in micrognathus. These have often been misdiagnosed as congenital deformities in the past. Since growth of the mandible takes place by endochondral bone formation at the condyle, apparently temproromandibular arthritic involvement—when it occurs—causes cessation of growth. It is interesting to note that there is little dysfunction in spite of the cosmetic disturbance in these patients.

We have, for some time, been interested in some physiologic aspects of growth relating to renal function. Although nephrogenesis is complete by the 35th fetal week, glomerular tufts are lined by cuboidal or columnar rather than squamous-epithelium in premature and full term infants. This probably is the cause of immature renal function values as demonstrated by various studies when contrasted to the adult even when adjusted to body weight or surface area standards. Thus inulin clearance values as measurements of glomerular filtration rate are approximately half the adult value when adjusted to the same surface area; similar observations have been made of renal plasma flow or maximal tubular excretion as determined by PAH clearance studies. These studies have considerable clinical significance. The young infant can get along satisfactorily until difficulty arises. He can't clear electrolytes or any other load which may be thrown on his renal excretory mechanism as efficiently as the older child. Thus fluid and electrolyte administration during early life require careful consideration which takes account of these physiologic limitations. We have observed renal phosphate clearance in newborn infants to be considerably lower than values obtained in older subjects. This, combined with the relatively high phosphorus content of undiluted cows milk feedings may contribute in some instances to the development of neonatal tetany. Phosphate clearances in infants older than one month are considerably improved; this may in turn be linked to improved parathyroid function.

In some studies we have done, we have applied this information in therapy. By administering one-half grain of a sulfonamide mixture per pound of body weight subcutaneously once every 24 hours in infants under two months, we have maintained adequate therapeutic sulfonamide blood levels. In infants over two months renal function was sufficiently mature so that the results were not nearly so constant. With penicillin therapy, Barnett and others have shown that it is also possible to administer doses at less frequent intervals than is generally recommended for older individuals and still maintain satisfactory blood levels. These limitations of renal function probably explain, in part, the tendency for the development of salicylate intoxication, predominantly in infants.

We may even think of growth in terms of biochemical reactions. It has been well demonstrated that the premature—and to a certain extent the full term—infant is not capable of metabolizing tyrosine as well as the mature organism. It has also been observed that ascorbic acid, and to a certain extent, folic acid can eliminate this metabolic "defect." Further studies will some day elucidate the "growth" of

biochemical processes probably in terms of enzyme systems.

One might even speculate that most of our future information concerning growth of the fundamental unit—the cell—will some day come from studying disordered growth in the form of neoplastic disease. Folic acid antagonists are an example of such recently acquired experimental tools. They convert dysplastic bone marrow of acute stem cell leukemia to mature marrow. While these tools do not yet cure the disease (although they have increased survival time in many instances) they might lead the way to a better understanding of disordered cellular metabolism and subsequently to more effective therapeutic agents. I am certain that studies of molecular structure of normal and abnormal enzyme systems will eventually solve the problems of growth which represent a joint project for the biochemist and the clinician.

DISCUSSION

*Dr. Max Samter, Assistant Professor of Medicine*: Of the diseases of infancy, atopic dermatitis—with some exceptions—seems to be limited to a definite period of the infant's life. In many cases it begins shortly after birth, persists to from eighteen to twenty-four month, then clears spontaneously. What are the changes of growth which take place during this particular period of life and how could they be related to the change in the incidence of atopic dermatitis?

*Dr. Richmond*: This is too big a problem to be explained by facts now known. We might conjecture that it is related to subtle aspects of endocrine maturation which affect the skin. It is known that the adrenal undergoes considerable involution shortly after birth. Since ACTH and compound E have been studied, the role of the adrenal in allergy has become more evident. It is possible that many adrenal insufficiencies during the first year of life go unrecognized. They may be manifested merely as vomiting or a failure to thrive normally. Other possible mechanisms include a more permeable gastrointestinal tract or too rapid increase in the diet. We believe the gastrointestinal tract becomes less permeable with increasing age. I wish I could answer your question more adequately since atopic dermatitis is one of the greatest headaches of pediatric practice.

*Dr. Ford Hick, Professor of Medicine*: Is there a qualitative difference in temperature regulation in children?

*Dr. Richmond*: Diurnal temperature variation is not well established until near the end of the first year. We do not know why.

*Dr. Robert W. Keeton, Professor of Medicine*: Is the surface areas reliable metabolic guide in the years from two to six?

*Dr. Richmond*: It does appear to correlate better than any other guide with the possible exception of creatinine excretion which is a more accurate reflection of muscle mass as proposed by Talbot.

*Dr. Samter*: I am not certain whether this question is based on correct reasoning but I have often wondered why malignancies appear to be uncommon in infancy even though growth in general is stimulated.

*Dr. Richmond*: Malignancies have become an increasingly important problem in pediatrics. Whether the increase is more apparent than real we don't know. It may be that with lower mortality rates as a result of better infant care and control of infectious diseases more children are surviving to develop neoplasms. Hence, there may be an absolute increase. At the Boston Childrens Hospital recently 3½% of autopsies have demonstrated malignant tumors.

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

# An Unusual Case of Gallstone Ileus

**I. F. Stein, Jr., M.S., M.D.*, and Karl A. Meyer, M.D., F.A.C.S., F.I.C.S.****
**Chicago**

The patient was a 47 year old white female who was admitted to the hospital on February 16, 1950 with the following complaints: vomiting—four days; abdominal pain—four days; no passage of flatus or bowel movement—four days.

On February 12, 1950 after eating a small lunch the patient had a gradual onset of upper abdominal and periumbilical cramping pain, followed by nausea and vomiting. During the next four days the patient vomited whenever she attempted to eat, and continued to have frequent episodes of abdominal pain. This cramping pain lasted for a few minutes and was accompanied by borborygmus. She had not passed gas nor had a bowel movement in four days.

The patient had pulmonary tuberculosis in 1930 and was in a sanitarium for a year and a half after which she was asymptomatic until two years ago, when she developed malaise, loss of weight and a cough. She was told that her tuberculosis had become active, but refused hospitalization and remained at home in semi-isolation.

During the past few years she had occasional attacks of upper abdominal pain associated with vomiting. These episodes usually lasted one or two days.

In 1926 she was operated upon for appendicitis, and was told after surgery that she also had salpingitis.

Physical examination revealed a thin, moderately dehydrated, white female who appeared acutely ill. There were moist rales, tubular breath sounds and dullness to percussion in the left upper lung. The abdomen was soft and flat with slight tenderness in the right upper quadrant. The bowel sounds were infrequent but of a high pitched tinkling character when present. There was a lower abdominal midline scar.

The rectal temperature was 99.0°F., the pulse 120 and the respirations 18. The blood pressure was 110/80.

Examination of the blood revealed an erythrocyte count of 4,500,000 with a hemoglobin of 80% and a leukocyte count of 12,000. The Kahn test and the urine were negative. An x-ray of

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Figure 1. Barium enema showing diverticulosis in descending and sigmoid Colon.



Figure 2. Barium meal showing cholecystoduodenal fistula and distended jejunum.



Figure 3. Twelve hours after Barium meal showing complete jejunal obstruction.

the abdomen showed a moderate amount of gas, but no definite pattern. Barium enema revealed diverticulosis in the descending and sigmoid colon. Figure 1.

The patient was given 60cc. of mineral oil by mouth after the stomach had been emptied. Intravenous fluids were administered and later continuous intragastric suction was started.

On the following day, February 17, 1950, the x-ray of the abdomen was unchanged. She passed a small amount of gas, but continued to vomit in spite of the functioning Levin tube. On February 18th, the temperature was 98.0°F., pulse 80, and respirations 20. Abdominal cramps continued and she passed gas on two occasions. On the 19th, the patient had an episode of right upper quadrant pain and vomiting. There was moderate tenderness in the right upper abdomen which had subsided on the 20th. The patient had a bowel movement on the 21st and the Levin tube was removed. On the following day the patient began vomiting again and the Levin suction was restarted. On the 23rd, she had a watery light brown stool and complained of pain throughtout the right side of the abdomen. The condition was essentially unchanged on the 24th. The patient was having small infrequent bowel movements some of which contained mineral oil. There was, however, a slight increase in abdominal distention and tenderness. It was suggested at this time that a swallow of contrast medium (Umbrathor) be given in an attempt to arrive at a definite diagnosis.

On February 25, 1950, by mistake, she was given a barium meal. We saw the patient, for the first time, twelve hours after the administration of barium. Serial films were available at this time which showed: 1) a small diaphragmatic hernia, 2) an irregular filling defect to the right of the first portion of the duodenum, (Figure 2) 3) several markedly distended loops of jejunum filled with barium, and 4) complete obstruction of a loop of jejunum on the left side of the abdomen, beyond which no barium had passed in 12 hours. (Figure 3.)

The patient was transferred to our surgical service and operated upon without delay. Under spinal anesthesia an upper left rectus incision was made. A small amount of serious exudate was present in the peritoneal cavity. A distended loop of jejunum presented which lead to the right to an area of tuberculous peritonitis. There were numerous caseous tubercles on the bowel and mesentery, but no obstruction in this area. On following this distended loop to the left, a solid object was encountered within the lumen of the jejunum. The bowel was opened and a gallstone measuring 5 x 4 x 3½ cm. was removed. Further brief exploration revealed 1) an inflammatory mass in the region of the gall

bladder involving the omentum, duodenum and hepatic flexure of the colon; 2) sigmoid diverticulosis without any evidence of adhesions or inflamation; 3) several adhesions of the omentum to the old lower abdominal scar. Nothing was done other than the removal of the gall stone and closure of the bowel.

The post-operative course was uneventful. The patient was given penicillin, 100,000 units every three hours and streptomycin, 1 gm. every six hours, for forty-eight hours after which she became afebrile and the dose of these drugs was reduced. She had a large bowel movement twelve hours after surgery, followed by diarrhea for two days. The skin sutures were removed on the 10th post-operative day at which time the wound was completely healed. In view of the tuberculous peritonitis, the patient was advised to have streptomycin therapy for two months. She did not wish to follow this advice and signed her release, leaving the hospital on the 12th post-operative day, at which time she was asymptomatic.

## DISCUSSION

This case is unusual from several aspects. There was a multiplicity of lesions: 1) Bilateral pulmonary tuberculosis with unilateral cavitation 2) tuberculous peritonitis 3) adhesions to the old abdominal incision 4) diverticulosis 5) diaphragmatic hernia 6) pericholecystic phlegmon with cholecysto-duodenal fistula and 7) gallstone ileus. Any of the last six conditions could have produced the symptoms. The favored diagnosis, before the barium meal showed a complete small bowel obstruction, was tuberculous peritonitis, thus non-operative treatment was employed, for this condition rarely causes complete bowel obstruction. When it was ascertained that the patient did have a complete bowel obstruction, immediate surgical intervention was employed, for there had already been a long period of conservative therapy and the obstructed loop was filled with barium which could only be removed by the alleviation of the obstruction.

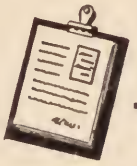
The *x*-ray films are of particular interest. The irregular filling defect to the right of the duodenum (Figure 2) probably represents barium which has gone through the cholecystoduodenal fistula, thus visualizing either the gall bladder or part of the common duct. The valvulae conniventes or plicae circulares of the small bowel ( and particularly the jejunum) are often seen in small bowel obstructions due to the filling of the obstructed loops with gas. It is most unusual to see these structures and the obstructed loops, as clearly as is shown on the films. We wish to emphasize that this patient was given oral barium by mistake, and that a barium meal is contraindicated in cases of bowel obstruction. The severity of the obstruction will become increased particularly if the barium solidifies. In addition if the intestine is opened and barium escapes into the peritoneal cavity, fatal peritonitis often results.

Finally, gallstone obturation usually produces obstruction of the middle or terminal ileum and it is unusual for such a large stone to erode into the intestine and obstruct the upper jejunum.

## SUMMARY

A case has been presented of high intestinal obstruction due to gallstone obturation, complicated by bilateral tuberculosis, tuberculous peritonitis, and phlegmonous cholecystitis with cholecystoduodenal fistula. Additional non-complicating factors were a diaphragmatic hernia, sigmoid diverticulosis, and multiple adhesions to a preexisting abdominal incision.

# CASE REPORTS



# Treatment of Severe Infectious Mononucleosis with Aureomycin

**Paolo Ravenna, M.D.**
**Chicago**

In recent years it has been discovered that infectious mononucleosis is a serious illness. The occurrence of edema of the larynx was described by Ravenna and Snyder[1] and a fatal outcome from laryngeal edema was reported shortly afterwards by Custer and Smith[2]. Neurological complications, including the Guillain-Barré syndrome, bulbar paralysis and encephalomyelitis have been recorded in previous years (Epstein and Dameshek[3]) and more often recently (Landes, Reich and Perlow[4]; Geliebter[5]; Ricker, Blumberg, Peters and Widerman[6]; Dolgopol and Husson[7]; and others). Rupture of the spleen and its fatal outcome has been mentioned often (Ziegler[8]; Fisher[9] and others), and hepatitis has been diagnosed in a disturbingly high percentage of cases (DeMarsh and Alt[10]; Bang and Wanscher[11]; Peterson[12]; Evans[13]; Sterling[14]).

Reliable recent statistics on the incidence of and mortality from infectious mononucleosis and its complications are not available. There is little doubt but that the prognosis is not as uniformly excellent as was believed less than ten years ago[15]. The recent reports of distressing complications may be due to an increase in morbidity or in severity as well as to more common recognition of the disease. It is clear, however, that infectious mononucleosis can no longer be regarded with complacency in every case.

The treatment of infectious mononucleosis has been confined to the supportive and symptomatic care as a result of the lack of favorable action of the sulfa drugs and of penicillin and streptomycin. Some hint that aureomycin may benefit has appeared in the literature (Dowling and co-workers[13]), but seems contradicted by others (Rose and Kneeland[14]).

This is the report of a case in which aureomycin was used in the treatment of a severely ill patient and it is my impression that it proved beneficial.

A robust twenty year old white student began

From the Dept. of Medicine, University of Illinois College of Medicine.

to complain of malaise and sore throat on September 18, 1949. The following day his temperature reached 100°F and the only abnormality was a uniformly inflamed throat with several small plaques scattered over both tonsils. Regional adenopathy was slight. He received 300,000 U. of procaine penicillin in oil. A throat culture for diphtheria was taken and reported negative.

The fever continued with a remittent curve with a maximum of 102.6° F and the malaise increased. The patient became restless, nauseated, vomited repeatedly, and complained of pain in the right upper quadrant of the abdomen. He felt and appeared severely ill. The exudate in the throat became confluent and on September 21 covered both tonsils completely. The cervical adenopathy increased considerably and marked enlargement of the axillary and inguinal nodes was noted. The spleen was clearly palpable and tender and the liver edge was felt 5 cm below the costal margin and was round, soft and tender.

Administration of aureomycin was started in the evening of September 21. One capsule (250 mg) was given every hour for twenty doses, followed by one capsule every three hours until September 26. The total amount administered was 12 Gm.

Twenty-four hours after the beginning of aureomycin treatment the temperature dropped to 99.6°F and the patient felt much better. The vomiting stopped, the nausea subsided and the throat was less sore. The swelling of all superficial lymphnodes had increased further by then and the liver reached to 7 cm and the spleen to 6 cm below the costal margin.

Thirty-six hours after aureomycin was started, the temperature was normal and remained normal thereafter. The following day the throat was almost clear and the lymphnodes, the spleen and the liver were not tender and much smaller in size. On September 26 the patient had apparently recovered: the spleen and liver were not palpable and the lymphnodes had regressed to normal size. The patient was kept at bed rest, against his strenuous objections, for another ten days and returned to his normal activities.

The significant blood findings are summarized in the table. The urine was normal throughout the illness except for a transitory slight albuminuria during the febrile period.

TABLE

| Date of test | Blood Total W.B.C. x 1000 | Lympho-cytes per cent | Hetero-phile antibody titer | Cephalin Flocculation | Thymol turbidity (units) | Van-den Bergh Direct | Total bilirubin mg per 100 cc |
|---|---|---|---|---|---|---|---|
| 9/22/49 | 19.5 | 75 | over 1792 | +++ | 8 | neg. | 0.3 |
| 10/5/49 | 10.4 | 72 | 896 | neg. | 14 | neg. | 0.4 |
| 10/14/49 | 7.5 | 44 | — | — | — | — | — |
| 10/24/49 | 6 | 42 | 112 | neg. | 4 | neg. | 0.4 |

COMMENT

There can be no doubt but that the case reported here was one of severe infectious mononucleosis complicated by hepatitis. The nausea and vomiting, the pain in the right upper quadrant of the abdomen and the enlargement and tenderness of the liver are evidence of hepatic involvement. In similar cases jaundice frequently appears and there is a protracted and severe course followed by a long convalescence[18]. Instead, within twenty-four hours after the administration of aureomycin was started, the fever dropped and in four days all the clinical manifestations of the disease had cleared up completely. The cephalin flocculation was negative two weeks later and the thymol turbidity returned to near normal limits in four weeks.

This case supports the contention that aureomycin may be effective in the treatment of infectious mononucleosis. The discordant opinions which have appeared in print so far may be explained by either inadequate dosage or the possibility that infectious mononucleosis may be due to more than one agent or strain, of varying sensitivity to aureomycin. It should also be noted that equivocal results may be observed because of the extremely variable clinical course, which makes it difficult to evaluate the action of any drug. Obviously the best information can be obtained from acutely and severely ill patients, when one can safely predict a course of several weeks. It is for this reason that this case is reported, as it seems more informative than a series of patients either mildly ill or diagnosed after the peak of the illness.

*Addendum*: A study on Aureomycin in Infectious Mononucleosis (M. H. Seifert, V. L. Chandler and W. Van Winkle, Jour. A.M.A.

142: 1133 (Apr. 15, 1950) appeared after the present report was submitted for publication. It shows that the grouping together of cases of diverse duration and severity makes the evaluation of results more difficult. In addition, the administration of smaller initial amounts of the drug may be responsible for the apparently unsatisfactory results reported by these authors.

SUMMARY AND CONCLUSIONS

1. Infectious mononucleosis may assume a severe, prolonged and even fatal course.
2. The administration of aureomycin in a severe case complicated by hepatitis was followed by improvement within twenty-four hours and by apparent recovery in four days.
3. It is believed that aureomycin is effective in at least some cases of infectious mononucleosis. Failures may be due to insufficient dosage or to a special resistance of some of the strains of the still unknown agent of the disease.

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## SURGERY IN COLITIS

Nowhere in the field of surgery is careful surgical judgement and consultation between the surgeon and the internist more imperative than in the treatment of ulcerative colitis. Most operative procedures, especially in the fulminating cases, must be staged, beginning with the simplest procedure (usually ileostomy), and followed step by step, as the condition of the patient warrants it, by partial colectomy or complete colectomy. *Excerpt: Surgical Treatment of Ulcerative Colitis, William S. McCune, M.D., assistant clinical professor of surgery, George Washington University School of Medicine, Med. Annals of the Dist. of Columbia, Aug. 1950.*

# Electrocardiographic Changes in Infectious Mononucleosis

**W. F. Boehm, M.D., W. R. Rose, M.D., and H. N. Barnes, M.D.**
**Chicago**

As data on infectious mononucleosis accumulate, the protean nature of the disease becomes more apparent. Myocardial changes associated with this illness have been described by several investigators. The purpose of this paper is to report a case of infectious mononucleosis, during the course of which EKG changes, corresponding to those seen in acute pericarditis, were present.

Custer and Smith[2], in a system-by-system analysis of autopsies on eight patients who died of infectious mononucleosis, noted myocardial changes in six cases. The changes consisted of aggregates of lymphocytes sparsely distributed within the myocardium in the periphery of the smaller vessels. Round cells were also present in small numbers beneath the endocardium. No actual necrosis was noted and no real pericarditis was encountered. They cite Jersild's case in which an autopsy diagnosis of death from myocarditis, due to infectious mononucleosis, was established. Dolgopol and Husson[3] found moderate edema of the myocardium, with loss of striation in a few fibers, at necropsy on a fatal case of infectious mononucleosis with neurological complications.

Caudel and Wheelock[1], in describing nonspecific myocarditis, reported a case of infectious mononucleosis in which T wave changes were noted in serial cardiograms for a period of a few days. Jaffe, Field and Master[8] obtained EKGs on 22 patients with infectious mononucleosis, and found significant deviation in nine of these. Lowering or inversion of T waves were the characteristic changes. Significant Q waves, QRS abnormalities, or ST segment deviations were not found. They did not find clinical evidence of active carditis in any of these patients. Evans and Greybiel[4] reported four cases of infectious mononucleosis with T wave changes consisting primarily of lowering of the T waves, and, in one instance, inversion of T4. These abnormalities persisted from six to 41 days. Geraghty[5] described a case of infectious mononucleosis in a 14 year old boy, in which T changes were noted. The abnormalities did not disappear within a period of one month. Gloyne[6] reported a case with transient EKG changes resembling those found in pericarditis, but because of the disappearance of T wave changes in five days or less, he felt that the changes were more probably due to myocarditis with rapid repair.

Case Report: The patient, D. B., is a 17 year old white male high school student. Except for mumps and measles in early childhood, past history was negative.

On April 22, 1949, he engaged in strenuous physical exercise (41 consecutive "push-ups"). That day he was exhausted, and during the following week he "did not feel up to par." He states that he was weak and tired, and that he had an occasional "dizzy spell."

He awoke from sleep at the usual hour on the morning of April 29, and immediately became aware of pressing substernal pain which radiated to and down the left arm, and was severe enough to cause him to "break out in a sweat." His mother took his temperature at that time and found it to be 102°. A hot water bottle was applied to his chest, and at the end of one hour the pain had subsided. Next morning it recurred in milder form, and was rather promptly relieved by heat. The pain has not returned. However, his temperature continued to fluctuate, ranging from 98.6° in the morning to 102° at night.

On May 4 he was seen by one of us (W. F. B.). Physical examination on that date revealed a slight reddening of the nasal and pharyngeal

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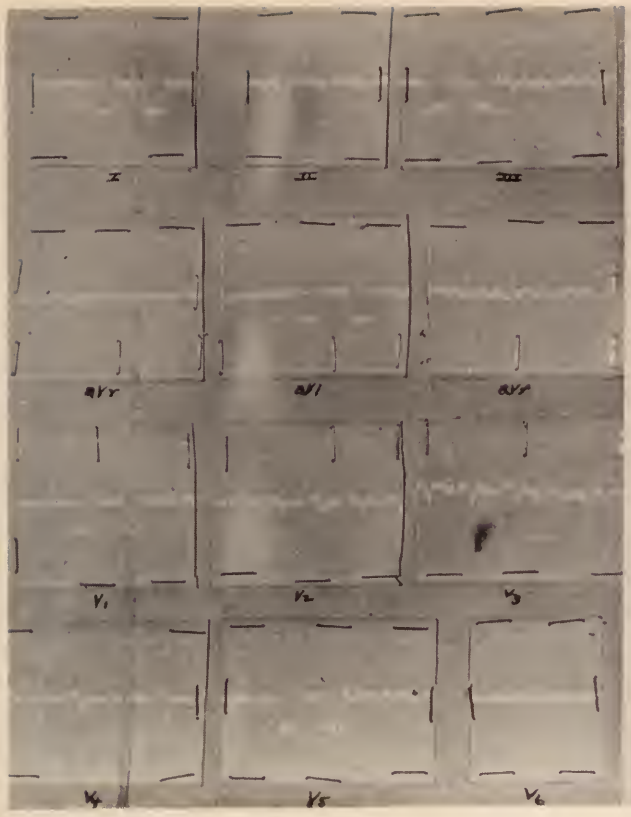


Figure 1

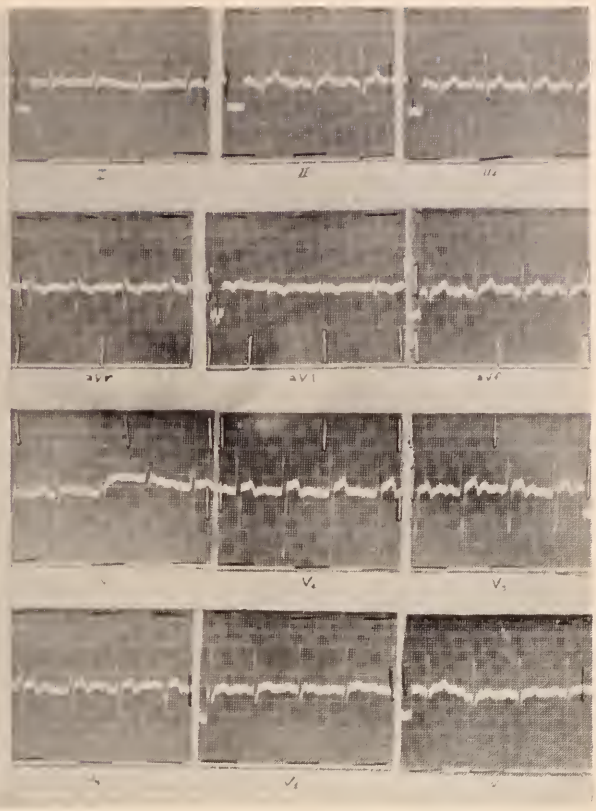


Figure 2

mucosa, moderately enlarged posterior cervical, inguinal and left epitrochlear lymph nodes, and no other abnormalities. A blood smear, taken at home, revealed 20% atypical lymphocytes, 64% small lymphocytes, and 16% polymorphonuclears.

He received 300,000 units of penicillin in oil daily for one week. His temperature continued to fluctuate, reaching 104° on two nights. This was associated with slight malaise. On May 9 and 10 he was afebrile, but next day his temperature rose to above 100°. On that day he complained of sore throat, but noted that the malaise had disappeared. Penicillin injections were renewed on the 13th and continued until the end of May. He entered the Lutheran Deaconess Hospital, Chicago, on May 15.

Physical examination on admission revealed a well developed and nourished, 17 year old white male who did not appear acutely or severely ill. Temperature was 99.8°. His pharynx was moderately injected. The cervical, axillary and inguinal lymph nodes were enlarged up to two cm., firm and non-tender. On percussion the heart was not enlarged. There was increased dullness to percussion over the splenic area, and on abdominal palpation left upper quadrant tenderness was noted, but the spleen could not be felt. The remainder of the examination was not contributory.

Blood studies on admission revealed a white blood count of 10,000, with 26% atypical lymphocytes, 50% small lymphocytes, 10% large lymphocytes, 14% polymorphonuclears, and a heterophile antibody titer of 1/1280 (eight days later the titer had risen to 1/2540). Sedimentation rate was 10 mm/hr. (Cutler). A chest x-ray revealed slight prominence of the outline of the right heart. Urine and red blood counts revealed no abnormalities.

Because of the history of chest pain, an electrocardiograph was obtained on May 17 (Figure 1). It showed coving of ST1, aVL, V2, V3, V4, V5 and V6, with inversion of the corresponding T waves, and depression of ST aVR with a diphasic T aVR. There were no abnormal Q waves. This pattern corresponds to that of pericardial lesions.

With this presumptive evidence of pericarditis at hand, the patient was reexamined several times daily throughout his hospital stay in an effort to detect a friction rub or signs of cardiac

enlargement, but no such findings could be elicited.

Serial tracings were obtained at approximately 48 hour intervals. These showed no significant changes until May 31 (Figure 2), when a lessening of the elevation and coving of the involved ST segments was seen. T1, V2, V3 and V4 were diphasic, and T V5 and V6 were upright. Subsequent tracings showed a gradual return toward the normal.

Hospital treatment consisted of bed rest, penicillin in oil, and chloromycetin, in an initial dose of 1000 mg. on May 17, then 250 mg. every four hours for 48 hours, and finally 250 mg. every six hours for eight days.

Subjectively the patient had no complaints throughout his stay. A low-grade fever persisted until May 21. The enlarged lymph nodes diminished markedly in size. On the last day of hospitalization the sedimentation rate was 6 mm/hr.; the white count was 5,900, with 1% atypical lymphocytes. He left the hospital on June second.

Since then his activity has gradually been increased. Subsequent white counts were within the normal range, and heterophile antibody titer fell to 1/320. On July 14 a normal cardiogram was obtained.

## DISCUSSION

The EKG changes described are not specific. Similar alterations may appear in acute pericarditis, acute anterior myocardial infarctions, or, less likely, in coronary insufficiency. However, the absence of Q waves, the lack of clinical evidence, the age of the patient, the atypical changes revealed in serial electrocardiograms, and the eventual return of the EKG picture to normal, all militated against the possibility of infarction. Coronary insufficiency was not tenable for the same reasons.[7, 10, 11]

The possibility remained that they might have been due to non-specific myocarditis involving particularly the subepicardial layers of the heart muscle; the consensus of opinion among those who have reported cases of cardiac involvement is that toxic myocarditis is responsible for the changes. This type of involvement can produce similar EKG changes, but they are usually confined to one or two of the chest leads. The widespread changes noted in our case—from V2 through V6 (i.e., almost the entire anterior and lateral surface of the heart)—is not in keeping with such a lesion.[8] The changes associated with non-specific myocarditis are usually more transient, completing their evolution within a few days,[1] while a normal tracing was not obtained in our case until July 14, two months after the first EKG had been taken and ten weeks after the onset of symptoms. In the cases previously reported, abnormalities of the ST segments were either insignificant or entirely absent;[9] in our case, ST changes were marked and persistent.

Failure to detect a pericardial friction rub does not rule out pericarditis. A friction rub may be transient and easily missed; autopsies on patients who succumb to myocardial infarctions reveal evidence of pericarditis much more frequently than could be predicted on the basis of rubs heard during the course of the illness. Moreover, our patient did have episodes of substernal pain; because of these the first EKG was obtained.

Enlargement of the cardiac shadow, of any great extent, is the exception, rather than the rule, in pericarditis of the acute benign type.

A final diagnosis has not been established in this case. The EKG changes alone could not be considered sufficient for the purpose, and other clinical and laboratory methods of approach failed to yield positive evidence either of pericarditis or myocarditis. However, in the opinion of the authors, the findings described suggested an episode of acute benign pericarditis, occurring as a complication of infectious mononucleosis.

Assuming this to be the case, it is possible that a dual etiology existed, i. e., that the patient suffered from infectious mononucleosis, and, concurrently, from an independent acute benign (viral) pericarditis. In view of the close parallel between the course of the primary disease as manifested by clinical and laboratory findings, and the EKG changes, and because of lack of supporting evidence for a dual etiology, this possibility was considered remote.

At present the scarcity of published data would seem to indicate that the occurrence of pericarditis as a complication of infectious mononucleosis is rare. As more cases of the latter disease are recognized, closer clinical and electro-

cardiographic studies may throw more light on this subject.

SUMMARY

A case is presented in which an attack of infectious mononucleosis in a 17 year old boy was accompanied by an episode of chest pain. An electrocardiogram revealed coving of ST 1, aVL, V2, V3, V4, V5 and V6, with inversion of the T waves in the same leads. Serial EKGs showed gradual disappearance of these changes, and within a period of two months a normal tracing was obtained.

The configuration, duration and eventual disappearance of these changes correspond to the electrocardiographic pattern seen in acute benign pericarditis.

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## ARE YOU A CITIZEN?

Dr E. O. Swartz, president of the Ohio State Medical Association, recently wrote of an experience which is worth repeating:

"Not long ago, one of my patients — a fellow who always has taken an active interest in community affairs — asked me, jokingly: 'Doctor, are doctors citizens?'

"The question puzzled me. Then I discovered that he had been reading statistics about the large number of professional and business men who have been slackers when it comes to taking part in political affairs and voting. Of course, my friend was trying to rib me. But, there is enough truth to his question to make physicians sit up and take notice.

"Apparently some people are not altogether sure of the answer to the question: 'Are doctors citizens?' Some political sources are trying to make the people think that the doctor is different from other citizens; that he has a different sort of civic obligation and a different sort of individual rights. Isn't it about time for the physician to stand up and be counted; to stand up and let the public know that he is a citizen and like other citizens has civic obligations and responsibilities?

"The Congressional elections on November 7 — in fact, the political campaigns which are now under way — will give the people of Ohio a good yardstick with which to measure the citizenship of the medical profession of Ohio.

"Is it a citizenship that influences government; a citizenship that is informed about candidates and political issues; a citizenship that means registration, working for able candidates, and voting? Or is it a negative and passive citizenship? Are doctors 'too busy' to fight for their citizenship, for the preservation of medical standards; for their professional freedom?

"The answer is up to you, Doctor. The testing time is here. It is time for doctors to prove that they are patriotic citizens, fully cognizant of their civic obligations and determined to live up to their great responsibilities." Enough Said. *Excerpt: Ohio State Medical Journal, July 1950.*

# NEWS OF THE STATE



## CHAMPAIGN

**Personal.**—Dr. Clarence Walter recently became anesthesiologist at the Carle Memorial Hospital and clinic, Urbana.

## COOK

**Personal.**—Recent honors awarded to Dr. Max Thorek include the following: honorary fellow, Medical Society of Vienna, Austria; fellow of the Royal Society of Medicine, England; fellow, University of Buenos Aires, Argentina; honorary fellow of the Surgical Society, Sao Paulo, Brazil; honorary fellow, Surgical Society, University of Padua, Italy; and honorary member of the National Academy of Sciences, Mexico.

**University News.**—Two new appointments have been made to the faculty of the Chicago Medical School it was announced recently. Russell O. Hanson, Ph.D., has been appointed instructor in pharmacology and physiology. Dr. Hanson is a graduate of the Illinois Institute of Technology and the University of Wisconsin. Dr. Gordon Cherwitz has been appointed full-time instructor in pediatrics. Dr. Cherwitz graduated at the Creighton University School of Medicine, Omaha.

**Name Medical Director of Heart Group.**—Appointment of Dr. Hugh McCulloch as Medical Director of the Chicago Heart Association was announced recently by Dr. G. K. Fenn, president of the Association. Dr. McCulloch has been associated with the Chicago Heart Association as Medical Director of its Council on Rheumatic Fever since January 1949.

Dr. McCulloch was one of the founders of the American Heart Association in 1922, and is a member at present of its Board of Directors and Executive Committee. He is the editor of *Pediatrics,* the journal of the American Pediatric Association, and is a nationally prominent authority in the field of rheumatic fever and rheumatic heart disease. He is a member of the Arthritis and Rheumatism Foundation and of the Technical Advisory Committee on Rheumatic Fever of the United States Children's Bureau.

An expanded program of research, community service and medical and lay education will be headed by Dr. McCulloch, with a medical advisory group of the Chicago Heart Association.

**Lecture Series on Blood.**—The annual fall lecture series began at the Chicago Medical School, October 11, and will be held throughout November 29 at 12:30 p.m. in Amphitheatre A. The lectures will be on the subject of Blood, with the final program given over to a display of the various medical and scientific exhibits prepared by members of the faculty. The schedule is as follows: October 11, Dr. William Bloom, professor of anatomy, University of Chicago School of Medicine, "The Genesis of the Blood Cells"; October 18, Dr. Carl Moore, professor of medicine, Washington University School of Medicine, St. Louis, "Iron Metabolism and the Iron Deficiency Anemias"; November 1, Dr. Robert W. Heinle, associate professor of medicine, Western Reserve University, Cleveland, "The Anti-Pernicious Anemia Substances"; November 8, Dr. S. C. Wang, associate professor of physiology, Columbia University College of Physicians and Surgeons, "Shock"; November 15, Dr. I. Davidsohn, professor and head of the department of pathology, Chicago Medical School, "The Serologic Aspects

of the Rh Factor"; and November 29, Exhibits, Faculty of the Chicago Medical School.

**Promotions At Illinois.**—Promotion of Drs. Carroll L. Birch, Ford K. Hick, Paul H. Holinger, L. J. Meduna, and Klaus R. Unna from the rank of associate professor to full professor in the University of Illinois College of Medicine has been announced by Dean Stanley W. Olson.

Dr. Birch, a member of the faculty of the Department of Medicine since 1926, has specialized in blood diseases and tropical medicine. She spent six months in England and other European countries in 1936 for the study of hemophilia, and six months in Africa last year for the study of African Sleeping Sickness and other tropical diseases. She holds doctor of medicine and master of science degrees from the University of Illinois.

Dr. Hick, an internist, has been a member of the UI faculty since 1931. He served in the U. S. Army as a medical officer for five years during the war. His principal research interests have concerned the reaction of circulation to different environmental temperatures. He holds doctor of medicine and doctor of philosophy degrees from the University of Illinois.

Dr. Holinger's work has been in the fields of bronchoesophagology and laryngeal surgery. He has developed techniques for photographing the air and food passages which have received international recognition. Dr. Holinger has served as president and secretary of the American Bronchoesophagological Association and as secretary-treasurer of the American College of Chest Physicians. He has been a member of the UI faculty since 1933, when he was appointed a resident in otolaryngology. He is a graduate of Northwestern University.

Dr. Meduna has gained recognition for his research contributions in psychiatry, especially the development of metrazol shock treatment which is regarded as the foundation for shock therapies in mental disease. Dr. Meduna has been an associate professor of psychiatry since he joined the UI faculty in 1943. He is the author of two books published this year, "Carbon Dioxide Therapy" and "Oneirophrenia." He received the doctor of medicine degree from the University of Sciences, Petrus Pazman, at Budapest, Hungary.

Dr. Unna has made notable contributions in the fields of the curare-like alkaloids, pharmacology of vitamins, intravenous ammo acid therapy, and construction of new pharmacological equipment. Dr. Unna joined the faculty in 1945 as an assistant professor of pharmacology, and since that time has devoted his research efforts largely to the field of curariform drugs and other muscle relaxants. He received the M.D. degree at the University of Freiburg, Germany, in 1930.

**Virus Laboratory Established.**—A Virus Laboratory unit has been established at the University of Illinois College of Medicine for the purpose of training virologists and maintaining a full program of research.

Several investigations already have been undertaken, with the support of the U. S. Public Health Service, the University's Graduate College, and Eli Lilly and Company, Indianapolis, Ind.

Current research studies involve influenza and mumps. Under the direction of Dr. John E. Kempf, an investigation is being conducted to study the virus etiology of certain skin diseases by the use of the electron microscope.

With the establishment of the Virus Laboratory unit, the Department of Bacteriology plans to take a major position in the training of virologists for the anticipated demands for teachers and research workers.

**Grants for Research.**—Three research studies in aviation medicine will be undertaken this fall by the University of Illinois College of Medicine for the U. S. School of Aviation Medicine at Randolph Field, Tex.

The Air Force has awarded grants in the total amount of $38,705 to the University for the studies.

Dr. A. C. Ivy has received a $17,200 grant in support of research studies on the mechanism and effects of aeroembolism.

An investigation to determine the effects of altitude stress in subjects with impaired cardiorespiratory function will be undertaken by Dr. Robert W. Keeton. He will receive $14,375 for the study.

A study of the effect of altitude on intra-abdominal lesions will be conducted under the supervision of Dr. Warren H. Cole. The grant for this research amounts to $7,130.

Three Chicago firms have awarded grants totaling $8,900 in support of research studies. The grants are as follows:

Armour and Company, $3,600, in support of an investigation of the eosinophile producing factor in the liver to be conducted by Dr. Robert M. Kark.

Consolidated Cosmetics, Chicago, $3,300, in support of a study of the mode of action of a substance used to destroy hair. This investigation is being directed by Dr. Adolph Rostenberg, Jr., in the Department of Dermatology.

Abbott Laboratories, $2,000, representing a renewal of a grant in support of the study of dietary therapy in liver disease. This investigation also is being conducted by Dr. Kark.

**Research in Heart Disease.**—The Chicago Heart Association announced September 5 the award of ten financial grants totaling $110,363 for research in heart disease. The Rheumatic Fever Research Institute of Northwestern University got a $25,000 grant. La Rabida Sanitarium received $24,416, and Dr. Albert Dorfman, University of Chicago School of Medicine, received $21,800 for research in conjunction with studies at La Rabida. Other grants and the amounts include $9,425 to Dr. George F. Simmons, Stritch School of Medicine of Loyola; $5,000 each to Dr. Arthur J. Gatz of Loyola and Dr.

George E. Wakerlin, University of Illinois College of Medicine; $6,490 to Michael Reese Hospital; $8,956 to Herrick House; $2,450 to Dr. Tilden C. Everson, University of Illinois; and $2,000 to Dr. Albert Milzer and Dr. Kate Kohn of Michael Reese Hospital.

**Mercy Hospital Installs New X-Ray Machine.**—An x-ray machine containing one million electron volts, said to be the first of the kind in the city, will be installed at Mercy Hospital Institute of Radiation Therapy under the directionship of Dr. Herbert E. Schmitz, it was recently announced. Dr. Schmitz is professor and chairman of the department of obstetrics and gynecology at Stritch School of Medicine of Loyola University, and head of the department of obstetrics and gynecology at Mercy Hospital. Engineers from the Chicago office of the General Electric X-Ray Corporation will install the unit.

According to Dr. Schmitz, the 800,000 volt machine has proven the value of supervoltage x-ray particularly in malignant conditions of the ovary, endometrial uterine tissue, cervix, breast and larynx. A report of the Institute, recently presented to the American Radium Society, showed a 43% five-year survival of patients with cancer of the cervix treated with 800,000 volt x-ray plus radium.

The new 1,000,000 volt machine will supplant an 800,000 volt unit which was the first x-ray machine in the "super-voltage" class ever to be installed. This took place in 1933, at a time when the use of supervoltage was in the pioneering stage.

The new million-volt unit will be the 13th medical million volt x-ray treatment machine in the world, and is similar in principle to apparatus of the same voltage now widely used to inspect castings, forgings and welds in industrial plants.

**Annual Public Relations Day Meeting.**—The Woman's Auxiliary to the Chicago Medical Society will hold an Annual Public Relations Day meeting, October 24, at the Blackstone Hotel. The speakers will include the following: Mr. Everett M. Dirksen, attorney and Republican Candidate for senator in Illinois; Mr. John W. Neal, general counsel, Illinois State Medical Society; and Dr. Warren W. Furey, past president, Chicago Medical Society, who will discuss various aspects of "Medicine in Public Affairs." Dr. Morris Fishbein will act as moderator.

## HANCOCK

**Eighty-Nine Years of Age.**—Dr. A. C. Runyon, Carthage, celebrated his eighty-ninth birthday August 6. He is still engaged in the active practice of medicine. He launched his practice in Ferris, March 1, 1884, later went to Elvaston, and for the past three years has been practicing in Carthage.

## SANGAMON

**Society News.**—Dr. Herbert C. Landis, professor of urology, Stritch School of Medicine of Loyola University, addressed the Sangamon County Medical Society, September 7, on "Diagnosis and Treatment of Vesical Orifice Obstruction".

## SHELBY

**Society Endorses Health Unit.**—The Shelby County Medical Society announced to the press recently that it does not favor the discontinuation of the Shelby county branch of the Shelby-Effingham health department.

## WABASH

**Health Officer Resigns.**—Dr. Dale E. Scholz has resigned as health director of the Lawrence-Wabash county health department, effective September 1.

## WOODFORD

**Dr. Morrison Honored.**—An open house marked the seventieth birthday and the anniversary of forty-five years of practice of medicine for Dr. Winfield Morrison recently. Dr. Morrison is the oldest practicing physician of Minonk. He was secretary of the Woodford County Medical Society for fifteen years, secretary of the grade school board for twelve years, county coroner for four years, a member of the County Sanatorium Board, and physician for the Illinois Central Railroad for twenty-five years.

## GENERAL

**Society News.**—Dr. Fremont A. Chandler, Chicago, Illinois, was chosen president-elect of the American Orthopedic Association recently and Dr. C. Howard Hatcher, Chicago, a member of the research committee.

**Heart Association Officers.**—The following physicians were recently elected as officers of the Illinois Heart Association: Dr. Edward W. Cannady, East St. Louis, president; Dr. Frank Deneen, Bloomington, vice president; and Dr. Robert W. Elliott, Alton, secretary. The physicians elected to membership of the Board of Directors include Drs. V. T. Austin, Urbana; Noland White, Centralia; John P. Doenges, Olney; Stanley L. Levin, Danville; Preston W. Sawyer, Kankakee; Thomas A. Starkey, Beardstown; B. T. Siegel, East St. Louis.

**Boston Clinical Congress Announced by American College of Surgeons.**—Dr. Paul R. Hawley, Director of the American College of Surgeons, announces that color television, clinics, postgraduate courses, forums, symposia, panel discussions, official meetings, films, hospital conferences and exhibits will vie for the attention of the several thousand surgeons and hospital representatives who will attend the thirty-sixth Clinical Congress of the College in Boston, October 23 to 27. Headquarters will be at the Hotel Statler. Meetings will be held there and at the Copley-Plaza Hotel, Mechanics Hall, Symphony Hall, and the New England Mutual Hall. Dr. Thomas H. Lanman is chairman of the Boston Committee on Arrangements.

The national emergency will affect the character of the discussions at many of the sessions, and every effort is being made to have the Clinical Congress contribute its share to promoting the medical aspects

of civilian defense and of care of the military forces, according to Dr. Hawley.

A new and exceptionally interesting feature of the program will be the holding of a series of post-graduate courses from Monday through Friday mornings at the Boston City, Peter Bent Brigham, Children's Massachusetts General, and Massachusetts Memorial hospitals. The subjects, to be presented at each hospital on different days, will be as follows: Nutrition, Vascular Diseases, Fractures of the Skull and Spine, Fractures of the Long Bones, and Pre- and Postoperative care.

Twenty-five Boston and vicinity hospitals will conduct clinics for the visiting surgeons every morning and afternoon during the Congress. Surgical procedures at Massachusetts General Hospital will be televised in color to Mechanics Hall every morning except Monday and every afternoon except Friday. Smith, Kline and French Laboratories of Philadelphia will furnish the television.

Thirteen Forums on Fundamental Surgical Problems in which the latest research findings will be presented, mainly by the younger surgeons, will be held Monday through Friday.

Symposia on Sports Injuries, Cancer, Trauma, and Graduate Training in Surgery, are planned — also a Clinico-pathological Conference.

Tuesday, Wednesday, and Thursday evenings, October 24-26, will be devoted to scientific sessions in general surgery, ophthalmology, and otorhinolarpngology. Afternoon panel discussions will also be held in these fields. On Friday afternoon there will be six surgical specialty panel discussions.

Conferences for hospital personnel will be held throughout the week under the direction of Dr. Malcolm T. MacEachern, Director Emeritus of the College.

Dr. Arthur W. Allen of Boston is chairman of the Board of Regents of the American College of Surgeons, which has a fellowship of 16,500 surgeons in the United States, Canada and other countries. The President is Dr. Frederick A. Coller of Ann Arbor. The President-elect, who will be installed at the Presidential Meeting on Monday evening, October 23, is Dr. Henry W. Cave of New York. The subject of Dr. Coller's Presidential Address will be "For the Benefit of the Patients."

Several hundred initiates will be received into fellowship at the Convocation on the final evening, Friday, when the Fellowship Address will be given by the Director, Dr. Hawley, whose subject will be "Quo Vadimus?"

Other main addresses will be the Fifth Martin Memorial Lecture at the Presidential Meeting by Professor Sir Geoffrey Jefferson of Manchester, England, on the subject, "The Balance of Life and Death in Intracranial Lesions," and the Fracture Oration on Wednesday evening by Dr. J. Huber Wagner of Pittsburgh.

## DEATHS

Francis C. Becht, Riverside, who graduated at Northwestern University Medical School in 1916, died September 14, aged 70, in MacNeal Memorial Hospital, Berwyn, of which he was one of the founders.

Jesse W. Carr, LaGrange, who graduated at Hering Medical College, Chicago, in 1895, died August 18, aged 82, while visiting in California. He was a former president of the La Grange Board of Health.

Fred Miller Drennan, River Forest, who graduated at Rush Medical College in 1913, died August 26, aged 66. He was clinical professor of medicine at Loyola University School of Medicine.

Charles E. Eisele, East St. Louis, who graduated at St. Louis College of Physicians and Surgeons in 1905, died August 28, aged 68. He was a member of the staffs of St. Mary's and Christian Welfare Hospital; he was president of the Southern Illinois Medical Association, and the St. Clair County Medical Society.

Edward F. Gollobith, Hanover, who graduated at the University of Illinois College of Medicine in 1908, died August 16, aged 66, while visiting in Minnesota.

Maurice B. Jacobs, Chicago, who graduated at the University of Illinois College of Medicine in 1935, died August 28, aged 39. He was a member of the Chicago Pathological Society.

Roy L. Kenward, Melvin, who graduated at the University of Illinois College of Medicine in 1932, died August 24, aged 43. He was on the staff of the Paxton Clinic.

Milton Mandel, Chicago, who graduated at Northwestern University Medical School in 1904, died August 28, aged 69. He was senior attending physician of Mercy Hospital and professor of clinical medicine at Loyola University School of Medicine.

George H. Musselman, retired, Galesburg, who graduated at the University of Illinois College of Medicine in 1909, died August 22, aged 67. He had practiced medicine in Winnetka before moving to Galesburg.

Edward Papik, Chicago, who graduated at Bennett Medical College, Chicago, in 1908, died August 20, aged 70.

William F. Petersen, Chicago, who graduated at Rush Medical College in 1912, died August 20, aged 63. He was director of the Department of Clinical Research at St. Luke's Hospital.

Robert Aaron, Reedy, Rockford, who graduated at the Chicago College of Medicine and Surgery in 1909, died June 25, aged 71, of uremia and hypostatic pneumonia.

Vasili V. Suntzeff, Quincy, who graduated at Northwestern University Medical School in 1938, died August 26, aged 55.

Paul E. Thal, Zion, who graduated at Chicago Medical School in 1922, died August 16, aged 63. He had practiced medicine in Chicago for 35 years.

Henri H. Weathers, East St. Louis, who graduated at Meharry Medical College in 1927, died August 2, aged 47.

# "FOR THE COMMON GOOD"

Health Talk on WGN-TV.—Since the last Illinois Medical Journal, the following telecasts have been presented over WGN-TV under the auspices of the Educational Committee:

Your Child Goes to School, August 21, Paul K. Anthony and Kenneth Nolan.

Your Sinuses, September 11, Raymond W. Kerwin. Civilian Defense, September 18, Sidney O. Levinson, Benjamin Boshes, Walter C. Bornemier, Mr. Robert Carnahan and Janet Sprickman of the American Red Cross, Mr. Robert Murrill U. S. Public Health Service, and Mr. Benn Leland, Cook County Department of Public Health.

Your Doctor Speaks over WFJL, Thursday evenings, at 7:15, carried the following transcribed broadcasts: Robert T. Stormont, September 21, Chemistry and Medicine. Edwin Leving, September 28, on Tuberculosis. George V. LeRoy, October 5, Liver Disease. James H. Hutton, October 12, The Menopause.

You and Your Baby over Station WAAF, Tuesday mornings at 10:30 a.m. presented the following physicians in live broadcasts. H. William Elghammer, August 29, The Second and Third Month of Life. George L. Drennan, Jacksonville, September 5, Immunization. Morley D. McNeal, September 12, A Mother's Love. L. Martin Hardy, September 19, Questions Parents Ask.

Here is Your Doctor Over Station WCFL, Sundays, at 11:45 a.m., carried the following physicians in transcribed broadcasts; Joseph N. Rappaport, Evanston, August 27-29, Importance of Preschool Examinations. George Cummins, September 3, on Stomach Ulcers. George A. Hellmuts, September 10, Understanding the Heart. Peter Rosi, September 17, Surgical Treatment of Peptic Ulcer. Herbert Nash, October 1, Sinusitis.

Dr. James P. Shortall, medical director of the Chicago Federation of Labor, appears as moderator in Here is Your Doctor; as-does Mr. Frank McGivern, publicity director, WCFL, is the announcer.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

Adrian Kraus, November 14, Hubbard PTA, in Chicago, Common Diseases of Childhood.

Vernon de Young, November 20, Woodfield Woman's Club, on Keeping Children Happy.

Eugene L. Slotkowski, November 20, Emotional Need of the Grade School Child.

Reuben C. Pearlman, Gage Park Woman's Club, November 28, on Plastic Surgery Today, illustrated.

Lectures Arranged by the Scientific Service Committee of the Illinois State Medical Society.

Irving Steck, Chicago, Effingham County Medical Society in Effingham, September 14, on Diagnosis and Treatment of Arthritis, illustrated.

Ormand C. Julian, and George Holmes, both of Chicago, before the Will-Gundy County Medical Society in Joliet, September 26, on Arterial Vascular Diseases of Lower Extremities and Surgery of Pulmonary Tuberculosis, respectively; both addresses were illustrated.

Fred O. Priest, Chicago, Bureau County Medical Society in Prenceton, October 10, on Bleeding During Pregnancy.

Paul F. Fox, La Salle County Medical Society in La Salle, November 9, on Pre and Postoperative Therapy, illustrated.

Richard B. Capps, Chicago, Whiteside and Lee County Medical Societies, in Rock Falls, November 9, on Diagnosis and Treatment of Heptatitis and Its Importance in Medicine and Surgery, illustrated.

Morris T. Friedell and Louis R. Limarzi, both of Chicago, Will-Grundy County Medical Society in Joliet, November 14, on Radioactive Iodine in Treatment of Thyroid Diseases and Treatment of Blood Dyscrasias, respectively; both addresses will be illustrated.

Theodore R. Hudson, Chicago, Kankakee County Medical Society in Kankakee, November 21, on Some Diagnostic Problems in Pulmonary Disease, illustrated.

Eugene T. McEnery, Iroquois County Medical Society, November 21, in Watseka, Asphyxia of the Newborn.

Mr. John Neal, Counsel, Illinois State Medical Society, McDonough County Medical Society, November 24, in Macomb, on Medical Legal Aspects of Personal Injury Cases.

Leonard M. Schuman, Springfield, Macoupin-Montgomery County Medical Societies, November 28, in Carlinville, on Poliomyelitis.

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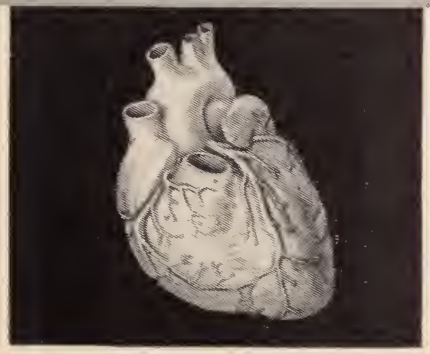
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(Editorial, The Lancet, Jan. 1, 1949)

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# PHYSICAL MEDICINE ABSTRACTS



## REHABILITATION OF THE AMPUTEE

Glenn Gullickson, M.D., and Frederic J. Kottke, M.D., Minneapolis, Minn. In THE JOURNAL LANCET, LXX:1:1, January 1950.

For centuries amputations of the extremities have been performed for the purpose of reducing invalidism, to remove useless extremities, and to save lives.

During the first World War, rehabilitation was recognized as a medical problem; the patient was no longer discharged as well when he could leave his hospital bed, but rather active therapy was given until he was ready to return to work.

Rehabilitation encompasses more than just the surgery, the healing processes, the restoration of function, and the fitting of artificial limbs. It must also take cognizance of the psychic trauma, and the necessity for physical, social, and occupational adjustment. For this reason, rehabilitation is not to be considered a specific phase of treatment, but rather a continuous process, which begins at the time of injury and continues until the patient has obtained maximal functional use of his prosthesis and is able to perform the essential activities necessary for daily living and gainful employment.

*Physical Therapy.*—Immediately following surgery a well-planned regime of physical therapy is instituted. The objects of physical therapy are: (1) To prevent or correct deformity. (2) To provide realignment of the extremity. (3) To establish muscle balance. (4) To increase muscle strength. (5) To maintain normal range of motion. (6) To prepare the stump for the prosthesis.

*Occupational Therapy.*—Occupational therapy is an integral part of the rehabilitation process. Early, diversional occupational therapy is given to help prevent the despondency which often occurs.

*Vocational Rehabilitation.*—When the patient has been fitted and taught the maximal function available from the use of his prosthesis, vocational rehabilitation is indicated, if he is still within the wage-earning age group and his disability is such that he cannot return to his former occupation. The State Division of Vocational Rehabilitation is consulted, and the patient is given aptitude tests, vocational guidance, and further training as indicated, so that he may be fitted to a position which he is capable of performing with his disability.

In concluson, it should be emphasized that an over-all program of rehabilitation is necessary to obtain maximum benefit for the amputee so that he can be self-sufficient and self-supporting. Although such an extended program as is used by the Army and Navy is impossible in civilian hospitals, much can be done through cooperation

(*Continued on page* 48)



## Patient Under Treatment

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The action of orally administered Pyridium often enables patients to carry on without interruption of normal pursuits throughout the course of specific treatment of uncomplicated cystitis, urethritis, and pyelonephritis.

This effective urinary analgesic relieves distressing symptoms such as urinary frequency and pain and burning on urination, without systemic sedation or narcotic action.

*Pyridium is the trade-mark of Nepera Chemical Co., Inc., successor to Pyridium Corporation, for its brand of phenylazo-diamino-pyridine HCl. Merck & Co., Inc. sole distributor in the United States.*




*The complete story of Pyridium and its clinical uses is available upon request.*

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(Brand of phenylazo-diamino-pyridine HCl)

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*In Canada:* Merck & Co. Limited—Montreal, Que.

of the surgeon, psychiatrist, limb-maker and vocational counselor in order to obtain better results in restoring the amputee to a useful, active life. Mitchell has pointed out that the percentage of persons who have undergone amputations returning to almost complete activity is capable of increase, not through the adoption of new methods, but through more efficient application of the principles already known.

---

### THE REHABILITATION OF THE PARAPLEGIC

Harry Kessler, M.D., and Arthur S. Abramson, M.D., Bronx, New York. In NEW YORK STATE JOURNAL OF MEDICINE, 50:1:43, January 1, 1950.

The presently accepted definition of rehabilitation is the maximal degree of physical, mental, social, vocational, and economic recovery which is attainable in the case of a given disability. While the factors involved in each indivdual patient will vary to the extent that greater or lesser stress must be placed on one or the other of the attainable goals we have just mentioned, it becomes obvious that a thorough survey of the patient and his environment, from every conceivable standpoint, is a necessary prerequisite to the establishment of a program which will serve the ultimate purpose. Furthermore, while the patient's disability must always be considered from a purely medical standpoint — else we shall have no rehabilitation program by virtue of the fact that we shall have no patient — as convalescence progresses, the emphasis is placed more and more upon his innate and residual ability, with the disability considered as a limiting border within which we may work and within which we may discover the solution to our problem.

The completely rehabilitated paraplegic, therefore, is one who is able to care for his daily needs without assistance, who is able to ambulate with braces and crutches, and who is reintegrated into society to the extent that he is able to make a living at a job for which he is fitted both mentally and physically.

It has been pointed out that the rehabilitation

(*Continued on page* 50)


**in psychosomatic and menopausal cases**





**Bellergal®** gives excellent results in relieving the functional disturbances of anxiety states, and in gastric and cardiovascular neuroses.

For treatment of that part of the psychosomatic disorder which involves dysfunction of both the autonomic and central nervous systems, BELLERGAL contains the most effective combination of drugs.

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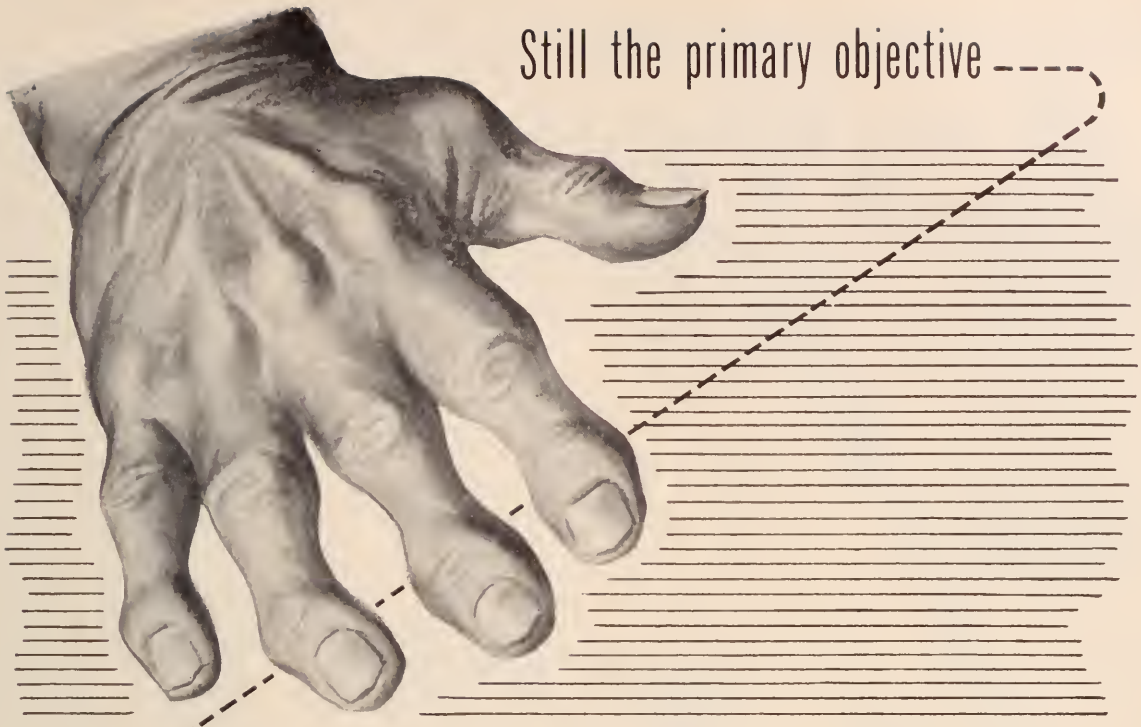
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Because of the buffering agents present, Salcedrox is readily tolerated by the gastric mucosa. Its content of calcium reduces the systemic toxicity of sodium salicylate and the calcium ascorbate corrects the vitamin C deficiency frequently seen in rheumatic states.

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Each Salcedrox Tablet supplies:

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|---|---|
| Sodium salicylate | 5 gr. |
| Aluminum hydroxide gel, dried | 2 gr. |
| Calcium ascorbate (equivalent to 50 mg. ascorbic acid) | 1 gr. |
| Calcium carbonate | 1 gr. |

**Salcedrox**
TABLETS





## Physical Medicine (Continued)

of the paraplegic actually commences at the moment of injury and is completed only when the patient can care for himself, ambulate with braces and crutches, is back home as an integral member of his family and society, and is gainfully employed.

The respective roles of the internist, neurosurgeon, plastic surgeon, urologist, psychiatrist, orthopedist, physiatrist, and associated technical personnel in the program of rehabilitation are described, and the importance of working together as a team is emphasized. Thus, there is a gradual change from dependency to self-reliance, both physically and psychologically, coincident with the development of rehabilitation toward its ultimate goal.

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### PREVENTIVE MEDICINE AND REHABILITATION

By Lieutenant Colonel, Charles D. Shields, M.C., U.S.A. Resident, Physical Medicine Service, Walter Reed General Hospital In The Military Surgeon, 105:6:451, December 1949.

The goal of rehabilitation is to render the victims of certain diseases and injuries capable of resuming their position, in the social order.

Physical Medicine is composed of Physical Therapy, Occupational Therapy and Rehabilitation. Rehabilitation is a field that is rather closely allied with preventive medicine even though they meet at extremes, the effort of one to prevent disease and injury, the effort of the other to rehabilitate those who have been its victims.

It seems not only possible but reasonable that official health agencies should add to their existing services those of rehabilitation. Health departments have already available case finding facilities and the few rehabilitation agencies that exist are chiefly supported by public funds. The Baruch Committee on Physical Medicine has published a report which outlines a model Physical Medicine — Rehabilitation center that might well be established as part of a community health service.

---

### EARLY RISING FOR PUERPERAL WOMEN

Allan B. Swarbreck, M.R.C.O.G., London. In BRITISH MEDICAL JOURNAL, No. 4659, p. 936, April 22, 1950.

From time immemorial it has been considered

(*Continued on page 52*)

# NOW, peak performance in non-narcotic COUGH CONTROL with ROBITUSSIN®

'ROBINS'




In Robitussin, Robins now makes available a potent new and different therapeutic weapon for the relief of cough. Its major component is glyceryl guaiacolate, shown by recent dependable investigative techniques to be unexcelled for its intense and prolonged action in increasing R.T.F. (respiratory tract fluid).[1,2,3] Also included in the Robitussin formulation is desoxyephedrine—an adrenergic agent to prevent bronchial spasm[5]—which lifts mood and improves patient's sense of well-being.[4] Robitussin's highly palatable aromatic syrup vehicle appeals to young and old alike. Robitussin makes expectoration easier and freer and diminishes dry, irritating cough. It is non-toxic, non-narcotic.

**USES:** Acute colds of head and chest, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, influenza and measles. Helpful as a palliative of harmful cough in tuberculosis, asthma and paranasal sinusitis.

**FORMULA** Each 5 cc. (1 teaspoonful) of Robitussin contains:

| | |
|---|---|
| Glyceryl guaiacolate | 100 mg. |
| Desoxyephedrine hydrochloride | 1 mg. |

In a palatable aromatic syrup

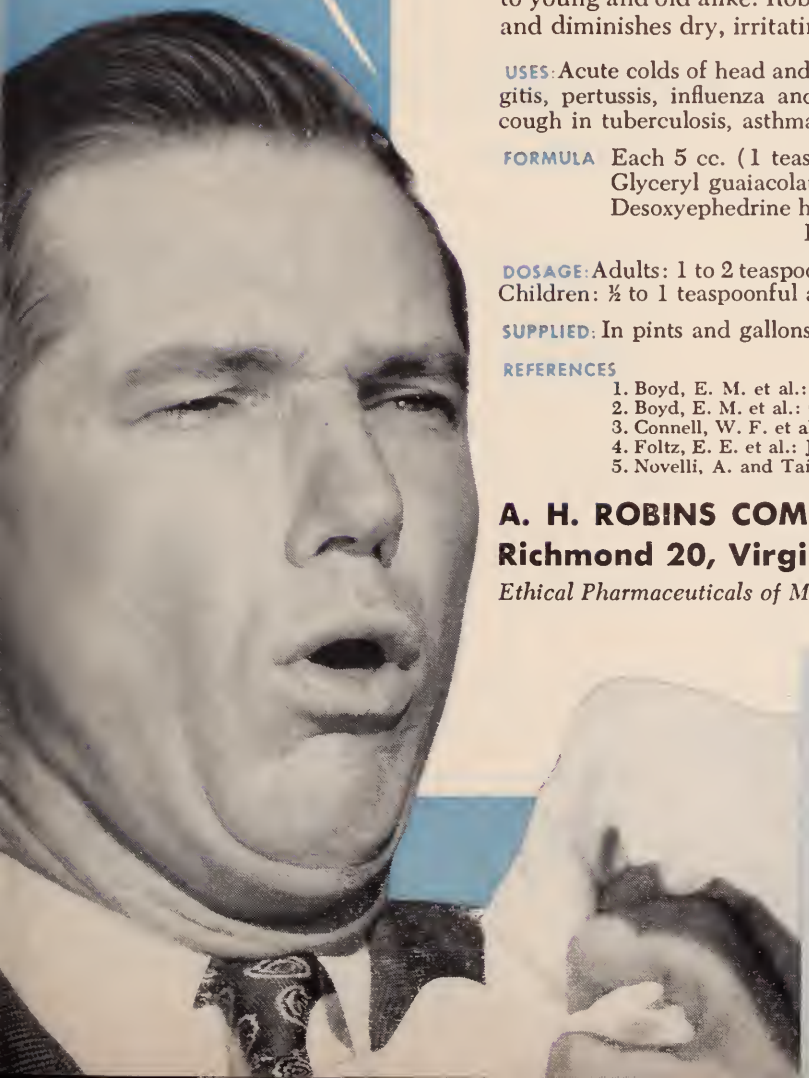
**DOSAGE:** Adults: 1 to 2 teaspoonfuls, repeated every 2 to 3 hours as necessary. Children: ½ to 1 teaspoonful according to age, 3 or more times daily.

**SUPPLIED:** In pints and gallons.

**REFERENCES**

1. Boyd, E. M. et al.: Canadian J. Res., 23:195, 1945.
2. Boyd, E. M. et al.: Canadian M.A.J., 54:216, 1946.
3. Connell, W. F. et al.: Canadian M.A.J., 42:220, 1940.
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5. Novelli, A. and Tainter, M. L.: J. Pharmacol., 77:324, 1943.

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**to facilitate productive cough . . .**
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desirable among civilized races for recently delivered women to remain in bed for periods varying from 10 to 28 days. This old regime certainly has the merit of enforcing rest in the puerperium, and has strong advocates in Jardine, Berry Hart and Peel. An effort to strike the balance between complete rest in bed and early rising has been made by Balfour Marshall (1912) and Shaw (1947), who consider that exercises and movement in bed should be encouraged.

This study presents the observations upon 828 women in the puerperium, of whom 23 underwent caesarean section. Of the remaining 805 who underwent vaginal delivery, 588 "clean" cases were admitted to the C wards, while 217 "potentially infected" cases were nursed in E ward. Only seven mothers in E ward were unfit for early rising.

The observations show that early rising seems to have no deleterious effects upon the women, those numerous differences which appear significant being partly explained by the accidental distribution to the wards after delivery. No difference was found between the remote complications, such as prolapse and retroversion. It is fully realized that observation over many years would be necessary to study the effects of early rising on prolapse. However, so many factors influence prolapse that correct control would be almost impossible. Early rising entails no risk to the recently delivered woman.

In favor of early rising, moreover, is the reaction of the woman herself. She feels fitter, has less trouble with defecation and urination when the bedpan is not necessary, and undergoes less puerperal depression. The nursing staff also feels that the regime is more satisfactory and tends towards the psychological well-being of the puerperal mother.

Finally, it is stressed that early rising is not suitable in domiciliary practice, where once the woman is ambulant the urge to meet her domestic obligations is irresistible. Nor is it to be used as a means of increasing hospital turnover by discharging the women earlier than hitherto. For a multiplicity of reasons it is still considered

(*Continued on page* 54)


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# *Chemically Standardized Veratrum Viride Is Effective in Hypertension*

Much has been written pro and con about the value of veratrum viride in hypertension. For many years the drug has been in disrepute because of the fact that the preparations available on the market have been prepared by "hit or miss" methods.

Chemical standardization of veratrum viride, however, has provided in this drug a highly effective agent for the treatment of hypertensive patients.

Sollmann[1] states that veratrum is probably the most active and reliable cardiac depressant and that its use serves to slow and soften the pulse and lower the blood pressure.

Willson & Smith[2] state that veratrum viride possesses a vasodilating effect and because of this, it was demonstrated by Hite,[3] and Freis and Stanton,[4] that the drug lowered pressure in hypertension and gave symptomatic relief. Recent research tends to show that the decrease in blood pressure results more from peripheral vasodilation than from depression of cardiac output.

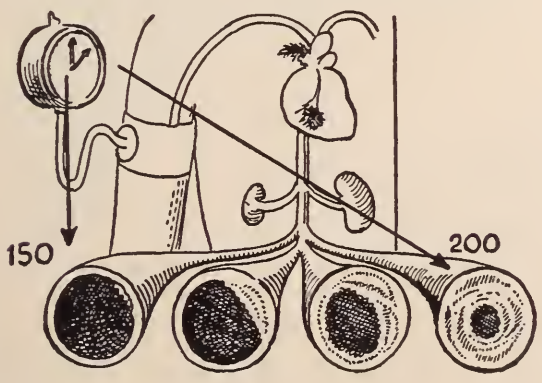
### *Uniformity of Action*

When the veratrum alkaloids are chemically standardized, a uniform result can be expected. Their action usually causes a reflex fall in blood pressure and heart rate which originates in the afferent vagus nerve endings in the myocardium of the left ventricle and in the lungs. Although these factors ordinarily result with each heart beat, the veratrum alkaloids cause them to act continuously over prolonged periods of time. Reports have shown that 80 to 90 per cent of hypertensive patients respond to therapy when chemically standardized veratrum viride is used.

### *Cardio-Vascular Symptoms Cleared*

In addition to the lowered pressure, objective signs of improvement may be observed, such as the clearing of retinal hemorrhages; diminution in cardiac size and reversal of left ventricular strain patterns in electrocardiograms.

Accompanying symptoms of the cardiac-hypertension syndrome, such as exertional dyspnea, tachycardia, nervous irritability, headache, are relieved. Yet, while the results of veratrum viride medication are prolonged, the drug may not afford quick relief.




### *Role of the Nitrites*

For prompt and effective fall in blood pressure, nitroglycerin, which acts in one to two minutes, is the drug of choice. It acts rapidly and, because of its powerful vasodilatory action, gives the patient almost immediate relief. The action of nitroglycerin, however, is fleeting and to sustain lowered pressure between the action of nitroglycerin and veratrum viride, an intermediate is necessary.

To this end, sodium nitrite is used. This drug is also a vasodilator and affords sustaining relief until the long range action of chemically standardized veratrum viride becomes effective.

### *Importance of Sedation*

Nearly all cases of hypertension require sedation for allaying periods of anxiety and affording the patient a good night's rest. Mild sedation is often useful, especially in cases associated with chronic coronary insufficiency.[5] It is well known that excitement may induce anginal attacks and in such cases, phenobarbital, because of its prolonged action, should be used.

All of these drugs, chemically standardized veratrum viride, nitroglycerin, sodium nitrite, and phenobarbital are to be found in Capsules RAY-TROTE IMPROVED, prepared by the Raymer Pharmacal Company of Philadelphia, Pa. Each capsule contains

| | |
|---|---|
| Phenobarbital | 15 mg. |
| Sodium Nitrite | 30 mg. |
| Nitroglycerin | 0.25 mg. |

With the equivalent of Veratrum Viride Tincture 4 minims (containing 0.1% alkaloids)

RAY-TROTE IMPROVED is effective in dosages of one capsule every three hours. It is contraindicated when renal insufficiency is present, or if pulse becomes abnormally slow following treatment.

For the 30% of hypertensive patients with capillary fault, the above formula, with 20 mg. of Rutin added, is available in RAY-TROTE with Rutin.

*Bibliography*

1. Sollmann: A Manual of Pharmacology, W. B. Saunders Co. (1942).
2. Willson & Smith: J. Pharmacol., 79:208 (1943).
3. Hite: Ill. M. J., 90:336 (1946).
4. Freis & Stanton: Am. Heart J., 36:723 (1948).
5. Falk: South. M. J., 40:501 (1947).

Send for a liberal clinical supply of RAY-TROTE IMPROVED Capsules and descriptive literature today to Raymer Pharmacal Company, N.E. Cor. Jasper and Willard Streets, Philadelphia 34, Pa.

essential to keep the recently delivered woman in hospital for a minimum of ten days, whereby she derives the benefit of the rest combined with the advantages of early rising.

### A METHOD FOR DECREASING REFLECTION OF MICROWAVES BY TISSUE

Jerome W. Gersten, M.D., Khalil G. Wakim, M.D., Ph.D., and Frank H. Krusen, M.D., Rochester, Minn. In ARCHIVES OF PHYSICAL MEDICINE, 31:5:281, May 1950.

That microwaves can heat tissues has been conclusively shown. Because of high reflection at the surface of the skin, however, the heating efficiency of these electromagnetic waves is low. In order to make the transfer of energy from air to tissues more efficient, an impedance matching device may be placed on the surface of the skin. Not only would this increase the transfer of thermal energy to the tissues, but it also might make it possible to heat small areas selectively, with inapprcciable elevation of temperature in the adjacent tissues.

The dielectric mycalex was tested in order to determine whether the anticipated decrease in reflection by impedance matching would be realized and thus result in more efficient heating of the tissues.

From this study the following conclusions were drawn:

(1) Impedance matching, by the placing of an appropriate dielectric between air and tissue, may be used to decrease the amount of microwave energy reflected by tissues.

(2) By the choice of certain combinations of current intensity and duration of irradiation, some areas may be heated satisfactorily while the adjacent areas receive relatively little heat.

### BEDS AND REHABILITATION

Leonard J. Yamshon, M.D., Los Angeles. In ARCHIVES OF PHYSICAL MEDICINE, 31:5:286, May 1950.

It is important to facilitate self care by permitting the patient to get out of bed and to be able to sit on the bed while dressing and un-

(*Continued on page* 56)


***A name to remember in Estrogen Therapy***

**SEStramin**
**(PATCH)**

Representing Sodium Estrone Sulfate + B Complex, C & D

**FEELING OF FITNESS** increased by the *two-fold* lift of estrogen sufficiency and B Complex sufficiency.

**ORAL THERAPY** preferred by many patients especially those who fear the needle. Levels "peaks-and-valleys" between injections.

**NO UNTOWARD SIDE EFFECTS** better tolerated than synthetics.

**INDICATIONS:** Natural and surgical menopause, functional amenorrhea and dysmenorrhea, suppresion of lactation.

**AVAILABLE in two STRENGTHS:**

**SEStramin 10M (light green tablets)**
Conjugated estrogens equivalent to oral activity of
Sodium Estrone Sulfate 1.25 mg.

**SEStramin 5M (light tan tablets)**
Conjugated estrogens equivalent to oral activity of
Sodium Estrone Sulfate 0.625 mg.

***In addition both formulae contain:***

| | | | |
|---|---|---|---|
| Brewers' yeast | 100 mg. | Pyridoxine hydrochloride | 1 mg. |
| Thiamine hydrochloride | 3 mg. | Calcium pantothenate | 5 mg. |
| Riboflavin | 2 mg. | Ascorbic acid (Vitamin C) | 25 mg. |
| Niacinamide | 10 mg. | Vitamin D | 500 I. U. |

SUPPLIED: Bottles of 20, 100, and 500 SEStramin tablets.

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When dissolved slowly in the buccal sulcus . . .

# LOZILLES

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dressing. It is realized that to have two sets of beds, a high one for the period of nursing care and a low one to be used at the time of self care is impractical and uneconomical. It is suggested, therefore, that the hospital beds be made adjustable so that they may be raised or lowered according to the patient's needs. With this in mind, two possible alternatives are suggested: (1) A telescoping inner post in the bedpost. This would permit the bed to be raised or lowered. The desirable height could be maintained by pins or bolts which transfixed both the outer and inner posts. (2) Adjustment of the level of the brace which supports the side bars of the bed. This can be accomplished in two ways: (a) by transfixing the brace to the bedpost at various levels by means of bolts — this is the simplest and most economical method — or (b) by using the principle of the automobile jack — the jack is fixed to the bedposts; the side bar brace is welded onto the top of the jack, so that by manipulating the jack, the desired height of the bed can be attained.

## INFLUENCE OF LOWER EXTREMITY AMPUTATION ON STANCE MECHANICS

F. A. Hellebrandt, M. D., Emily E. Mueller, M. S., Ida May Summers, M. S., Sara Jane Houtz, M. S., Mildred F. Heap, M. S., and Robert N. Eubank, Richmond, Va. In JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 142:17:1353, April 29, 1950.

The effect of lower extremity amputation on the location of the center of gravity, postural alinement and stance stability was studied on 24 unselected subjects. The accumulated evidence supports the following conclusions:

(1) Lower extremity amputation significantly elevates the height of the center of gravity.

(2) Prosthetic appliances compensate in part, but not in whole, for this displacement.

(3) The majority of amputees maintain the vertical projection of the center of gravity within the middle fifth of the transverse diameter of support and remarkably close to the geometric center of the base.

(4) Postural realinement is necessary to re-

(*Continued on page 58*)



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Harding, F. E.: West. J. Surg. Obst. & Gynec. 52:31 (Jan.) 1944

"All patients (53) described a sense of well-being" following "Premarin" therapy for menopausal symptoms.

Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943.

"It ('Premarin') gives to the patient a feeling of well-being."

Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95 (Feb.) 1943

"General tonic effects were noteworthy and the greatest percentage of patients who expressed clear-cut preferences for any drug designated 'Premarin.'"

Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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locate the center of gravity over the middle of the supporting base and should be considered a physiologic adaptation essential to efficient use of the prosthetic appliance.

(5) The principal realinement of the unilateral amputee occurs in the transverse vertical plane, as evidenced by a high incidence of compensatory scoliosis.

(6) The major anteroposterior adjustment made by both unilateral and bilateral amputees is increased tilting of the pelvis and lumbar lordosis.

(7) Improper alinement of the prosthetic appliance, inequalities in leg length and discomfort are reflected in malposition of the center of weight.

(8) Postural stability of the lower extremity amputee not only equals but supersedes that of normal young adult subjects when the eyes remain open.

(9) Reflex postural adjustments mediated by retinal simulation are significantly more important to the amputee than to normal subjects.

(10) Improper fitting or inadequate training in the use of lower extremity prosthetic devices augments the disabling effects of the handicap by introducing mechanically disadvantageous compensatory adjustments.

## COLD PRESSOR TEST FOLLOW-UP STUDY FOR SEVEN YEARS ON 166 OFFICERS

Major General Harry G. Armstrong (U. S. A. F.), Washington, D. C., and James A. Rafferty, M.D., Randolph Field, Texas. In AMERICAN HEART JOURNAL, 39:4:484, April 1950.

Empirical evidence in regard to the validity of the cold pressor test as a criterion of the risk of developing hypertension is presented in this paper. The test was administered to 166 officers on active duty in 1940, some flying, some nonflying. Their annual blood pressures and physical examinations were followed through to 1947. In 1940 certain cumulative experience in the medical literature indicated that the cold pressor

(*Continued on page 62*)


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**DOSAGE:** Add ½ to 2 tablespoonfuls to the day's feeding, or 1 or 2 teaspoonfuls to single feedings.

**SUPPLIED:** Two adaptable forms—**MALT SOUP EXTRACT** (Liquid) in jars containing 8 fl.oz. and 1 pt.; **DRI-MALT SOUP EXTRACT** (Powder) in jars containing 1 lb.

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When the patient resigns himself to mere existence during the middle period of life, depression can so easily get the upper hand. The seemingly endless, daily routine of living is approached with apathy, inertia and lack of interest; and the patient's own outlook on life drags him down the path to eventual break-up—physical as well as mental.

For such a patient 'Dexedrine' Sulfate is of unequalled value. Its uniquely "smooth" antidepressant effect restores mental alertness and optimism, induces a feeling of energy and well-being. By helping to revive the patient's interest in daily affairs, 'Dexedrine' has the happy effect of bringing back *life* for the living.
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**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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test could discriminate between normal individuals and prehypertensive individuals with normal blood pressures. When the testing was performed it was proposed that if these findings could be substantiated on flying officer personnel, the cold pressor test could be added to the collection of selection and classification technics of aviation medicine.


SUMMARY

A seven-year follow-up study of annual blood pressures and cardiovascular histories of 166 officers is analyzed statistically in regard to cold pressor tests administered to them in 1940.

Cold pressor test index is found not correlated with measures of hypertensive tendency, with age, with flying time, or with basal blood pressure.

Basal diastolic and systolic pressure, and the tendency to increase in systolic pressure in later life, are found correlated with age.

Basal diastolic pressure is found relevant to trends in diastolic and systolic pressure in later life.

The number of hours a career pilot has flown is found not correlated with hypertensive tendencies, provided he has passed careful physical examinations annually.


## PSYCHOSOMATIC ASPECTS OF LOW BACK PAIN: A REVIEW OF RECENT ARTICLES

Louis Paul, M.D., Ellis Island, N. Y. In PSYCHOSOMATIC MEDICINE, 12:2:116, March-April 1950.

Regretfully, diagnosis of psychogenic back disorder is frequently missed because the physician is not sensitized to the subtleties of musculoskeletal neurosis. It is easy to decry the diagnostic errors in cases of obscure back pain, many of whom have back-braces, or multiple manipulations and operations, or prolonged physical therapy, with resulting invalidism and fixation of symptoms, before referral to a psychiatrist. What is necessary is wider recognition of psychogenic musculoskeletal illnesses, and it is encouraging that worthwhile contributions toward this goal have come from orthopedists.

Nothing is more completely proved than the fact that approximately one-half of all cases of significant tuberculosis have no symptoms, or symptoms so slight as to escape notice. A. C. Christie, M.D., Pub. Health Rep., June 2, 1950.



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# BOOK REVIEWS



Essentials of Obstetrical and Gynecological Pathology: By Robert L. Faulkner, M.D. and Mary Douglass, M.D., 357 pages, 300 illustrations — 3 color plates. Second Edition, 1949. $8.75. C. V. Mosby Company, St. Louis.

The first edition of this book was published in 1939, and with newer knowledge concerning the pathologic changes in the many types of obstetrical and gynecologic conditions, the book in this revision was brought up to date. The authors realize the necessity for the student to have more knowledge concerning pathology in connection with gynecologic and obstetrical conditions. He, therefore, deemed it advisable to include pathologic considerations as a part in the clinical training of students in their obstetrical and gynecological studies.

Profound changes in the female generative organs may be due to physiologic variations, as well as in the endocrine system, which has such an important part to play in their respective functions. Then, of course, it is generally known that the many types of inflammatory processes and the various types of tumors add materially to the pathologic problems in their consideration.

The importance of thorough pathological study of all specimens removed at operation is stressed, and the desirability of early reports from the pathological department cannot be overstressed. These tissues, in order to permit the best possible study on the part of the pathologist, should be carefully handled so as to not destroy or disturb portions which may show disturbances, which otherwise might be overlooked.

In the book the various organs and structures in the female pelvis are carefully discussed, and the pathological changes in the various types of disturbances, are well brought out. Likewise those pathologic changes incident to pregnancy are discussed in much detail.

The 300 illustrations, three in color, add materially to the value of the book and it surely will be of great interest to students and practitioners alike. The general practitioner will find much in this volume which will well repay him for the time required to look through its pages.

---

A Century of Medicine in Jacksonville and Duval County: By Webster Merritt, M.D., 44 illustrations. University of Florida Press, Gainesville, 1949. $3.50.

Owing to the fact that all of the records of the Duval County Medical Society, as well as those of the Florida State Medical Association, were destroyed by fire in 1901, the author of this interesting book had a most difficult task before him when he began to search for records to develop his book.

The first physician arrived in this area probably in 1798, seven years after the first settler decided to live on land which later became Jacksonville. This first physician, James Hall, served his country during the Revolutionary War as a sergeant in the Third Regiment, New Hampshire volunteers. Existing records do not show where he received his medical education. Little is known concerning his many medical problems of the time.

Records concerning other physicians of a slightly later period in this area, show that they used bleeding extensively, and castor oil, calomel, blue mass, rhubarb, opium, turpentine, sulphur, and spirits of niter were available and constituted the major portion of their therapeutic armamentarium. There were many cases

(*Continued on page 66*)

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of malaria prevailing throughout the area, and as early as 1825 large doses of quinine were adminstered for this ailment.

The founding and early history of the Florida State Medical Association and the State Board of Health are presented, with stories of the early difficulties in getting these organizations established.

There are many fine illustrations in this book of unusual interest, which add materially to its worth to the seeker of medical historical data of the south. This is truly an interesting book, and one which will be of much value to those interested in the story of medical progress in Florida.

---

ELECTROCARDIOGRAPHY—Fundamentals and Clinical Application: By Louis Wolff, M.D. Visiting Physician, Consultant in Cardiology and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; Associate in Medicine, Harvard Medical School. 187 pages with 110 figures. Philadelphia & London: W. B. Saunders Company, 1950. Price $4.50.

The author has added to a long list of books, an additional text on the subject of electrocardiography. He states in the preface that many subjects are taught empirically with the student only having to memorize a few patterns and values. Thus, little knowledge is retained. He has approached his subject from the understanding of the basic principles of electrocardiography without reference to a pattern.

The book is divided into two parts: the basic principles of electrocardiography, and clinical electrocardiography. In the first part the how and why of electrocardiography is developed step by step according to physiologic principles. The author explains what is meant by depolorization, repolorization, exploring electrode, indifferent electrode, and unipolar leads. Instead of making his subject mechanical he has made it physiological.

The second part of the book develops from the principles of the first part. The usual cardiac conditions applicable to electrocardiography are discussed. Although brief, the author has accomplished a worthwhile end by producing a practical text on a technical subject by presenting an understanding instead of a collection of patterns.

J. W. F.

---

CHEMICAL DEVELOPMENTS IN THYROIDOLOGY, William T. Salter, M.D., Professor of Pharmacology, Yale University School of Medicine, New Haven, Connecticut. Charles C. Thomas, publisher, Springfield, Ill. 1950. Fabricoid cover. 87 pages. Price $2.00.

This is publication Number 26 of the American Lecture Series. The 87 pages of this booklet are divided into Introduction, Synthesis of the Thyroid Hormone, The Blocking of Thyroid Activity, Circulating Thyroid Hormone, Application of Radio-Iodine, Synopsis, Bibliography, Index.

(*Continued on page* 68)





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## BOOK REVIEWS (Continued)

The author, according to his statement in the introduction, focuses attention on four main types of study:

(1) Short-cut synthesis of the thyroid hormone by methods which imitate nature.

(2) The development of blocking agents which impede the natural synthesis.

(3) Studies of the peripherally circulating hormone.

(4) The application of radio-iodine to problems in physiology and therapy.

Of special interest to the clinician at this time is the section on the blocking of thyroid activity.

The book has added interest because of the magnificent work of Mr. Charles C. Thomas, publisher.

J.H.H.

---

Symptoms In Diagnosis. By Jonathon Campbell Meakins, C.B.E., M.D., D.Sc., LL.D., Formerly Professor of Medicine and Director of the Department of Medicine, McGill University; Formerly Physician-in-Chief, Royal Victoria Hospital, Montreal; Formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Fellow of the Royal Society of Edinburgh; Fellow of the Royal Society of Canada; Fellow of the Royal College of Physicians, London; Fellow of the Royal College of Physicians, Edinburgh; Honorary Fellow of the Royal College of Surgeons, Edinburgh; Fellow of the Royal College of Physicians, Canada; Fellow of the American College of Physicians. Illustrated. Williams and Wilkins, Baltimore. 1948. 542 Pages. $7.50.

This relatively brief book serves to bring out something that is too often overlooked in these days of superscientific medicine, and that is that a good history and the proper evaluation of symptoms is still the most important single procedure leading rapidly to correct diagnosis. Imterpretation of symptoms has become more rather than less important since we have come to understand better the discordered physiology which produces the complaint; advanced laboratory methods have resulted in a more precise interpretation of the symptoms of disease.

Dr. Meakins is one of our distinguished clinicians, and he has written a practical concise book which will be useful both to the young students and to the experienced physician. J. C. S.

---

Shearer's Manual of Human Dissection. Ed. by Charles E. Tobin, Ph.D. Associate Professor of Anatomy, The University of Rochester School of Medicine and Dentistry. 2nd Ed. Blakiston, Philadelphia. 79 Illustrations, 286 Pages. 1949. $4.50.

This is a manual of human dissection intended for actual use in the gross anatomical laboratory. It can be used alone or with one of the standard texts. The second edition has been corrected and reorganized to make it more useful. The text is clear and the illustrations adequate. J. C. S.

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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

EYES AND INDUSTRY (Formerly Industrial Ophthalmology) By Hedwig S. Kuhn, M.D. With 151 Text Illustrations, including 3 color plates. Second Edition. 378 pages. The C. V. Mosby Company, St. Louis, 1950. Price $8.50.

CARBON DIOXIDE THERAPY. A Neurophysiological Treatment of Nervous Disorders. By L. J. Meduna, M.D., 236 pages. Charles C. Thomas, Publisher, Springfield, Illinois. Price $5.00.

THE ANTIHISTAMINES, Their Clinical Application. By Samuel M. Feinberg, M.D., Saul Malkiel, Ph.D., M.D., and Alan R. Feinberg, M.D., 291 pages. The Year Book Publishers Inc., 200 East Illinois Street, Chicago. Price $4.00.

CEREBRAL PALSY By John F. Pohl, M.D., 224 pages. Bruce Publishing Company, Saint Paul, Minnesota, 1950. Price $5.00.

NON-GONOCOCCAL URETHRITIS, including the Genital Manifestations of Local and Systemic Diseases and Infestations of the Urinary Tract with Protozoa, Metazoa and Fungi. By A. H. Harkness, M. R.C.S., L.R.P., 424 pages. 167 illustrations. 73 in full colour. The Williams and Wilkins Company, Baltimore, 1950. Price $10.00.

CEREBRAL ANGIOGRAPHY. By P. Almeida Lima, M.D., 221 pages. Oxford University Press, London, New York, Toronto, 1950. Price $8.75.

CLINICAL EXAMINATION OF PATIENTS, with Notes on Laboratory Diagnosis. By John Forbes, M.D., M.R.C.P., and W. N. Mann, M.D., F.R.C.P. 323 pages. The Williams & Wilkins Company, Baltimore, 1950. Price $4.50.

THE ESOPHAGUS AND PHARYNX IN ACTION, A Study of Structure in Relation to Function. By William Lerche, M.D. 222 pages. Charles C. Thomas Publisher, Springfield, Illinois. Price $5.50.

NURSING IN PREVENTION AND CONTROL OF TUBERCULOSIS. By H. W. Hetherington, M.D., M.R.C.P. and Fannie W. Eshleman, R.N., B.S. Illustrated with photographs and charts. Revised third edition. 361 pages. G. P. Putnam's Sons, New York. Price $4.50.

DOCTOR COME QUICKLY. By Frank J. Clancy, M.D., 248 pages. Superior Publishing Company, Seattle. Price $2.95.

THE MODERN TREATMENT OF ASTHMA, with special reference to gold therapy. By L. Banszky, M.D., (Berlin), L.M.S.S.A. (Lond.) 135 pages. The Williams and Wilkins Company, Baltimore, 1950. Price $2.50.

THE MANAGEMENT OF OBSTETRIC DIFFICULTIES. By Paul Titus, M.D., 446 illustrations and 9 color plates.




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Fourth Edition. The C. V. Mosby Company, St. Louis, 1950. Price $14.00.

ATOMIC ATTACK — A Manual for Survival. By John L. Balderston, Jr., and Gordon W. Hewes. 55 pages. Published under the auspices of Council on Atomic Implications, Inc. Box 296 University of Southern California, Los Angeles 7, California. Price $1.00.

THE NATIONAL FORMULARY. Ninth Edition. National Formulary IX. Prepared by the Committee on National Formulary under the Supervision of the Council by authority of the American Pharmaceutical Association. Official From November 1, 1950. 877 pages.

SURGICAL NURSING. By Eldridge L. Eliason, A. B., M.D., Sc.D. F.A.C.S., L. Kafer Ferguson, A.B., M.D., F.A.C.S., Lillian A. Sholtis, R.N., B.S., M.S., Ninth Edition Revised and Reset. 728 pages. 366 illustrations including 9 subjects in full color. J. B. Lippincott Company, Philadelphia, London, Montreal.

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The continued responsibility for the care of a chronically sick person adds immeasurably to the education of a physician. It requires maturity to be able to recognize limitations, to avoid becoming angry because the patient does not get well, to avoid becoming discouraged or discouraging, and to continue to wish to help within the limits of one's ability. John Romano, M.D., J.A.M.A., June 3, 1950.

## AUREOMYCIN SHOWS PROMISE AS TREATMENT FOR MUMPS

Results obtained in treating three patients with mumps suggest that aureomycin, an antibiotic drug, may be of definite value in this disease, according to two doctors from Sayre, Pa.

Two women treated for mumps with aureomycin showed definite improvement within 24 hours after receiving the first dose of aureomycin, Drs. Wilfred D. Langley and John Bryfogle say in the August 12 Journal of the American Medical Association. Aureomycin was given to both women on the second day after swelling in the glands began.

Another patient, a man, received the drug less than 24 hours after symptoms of mumps were first noticed. Forty-eight hours after treatment was begun, he showed definite improvement.

"While no definite conclusions can be drawn from treating three patients in the manner described, the results obtained would suggest that aureomycin may be of definite value in this disease," the doctors point out.

---

South Africa holds two world records for tuberculosis death rates. It has the highest death rate in the world in respect to the natives, and the lowest in the world as far as the European population is concerned. W. Norman Taylor, M.D., D.P.H., The Health Educ. J., April, 1950.

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## FINDS PERSONS WITH BLUE EYES SUSCEPTIBLE TO CANCER CAUSED BY SUNLIGHT

Blue-eyed persons are more susceptible to cancer caused by exposure to the sun's rays than are brown-eyed persons, a study made by a Santa Monica (Calif.) doctor shows.

Racial stock apparently is an important factor in determining the amount of sunlight to which a person can be exposed safely, Dr. A. Fletcher Hall of the Graduate School of Medicine, University of Southern California, says in Archives of Dermatology and Syphilology, published by the American Medical Association.

Dr. Hall bases his conclusion on study of 100 persons with skin cancer.

"There are certain racial stocks and hereditary complexion patterns in which sunlight is not an important, if any, factor in skin carcinogenesis," Dr. Hall says. "These include certainly the Negro and Oriental races, probably the Mexican and Mediterranean and possibly all homozygous brown-eyed persons.

"There are certain racial stocks and hereditary complexion patterns in which sunlight is by far the most important carcinogenic factor when repeatedly encountered in erythema-producing quantities. These include certainly those of Irish-Scotch-English ancestry probably the blue-eyed North Europeans and possibly all homozygous blue-eyed persons.

"Observations suggest that the more brown-eyed inheritance a person possesses, the better protected he is from the carcinogenic rays of the sun. Blue-eyed children of blue-eyed parents are, in general, the most susceptible, but many of these are capable of tanning without repeated burning and thus acquire a fair degree of immunity."

## NAVY ASKS INACTIVE OFFICERS TO VOLUNTEER

Due to the shortage of physicians, dentists and nurses to meet the present day obligations, the Surgeon General of the Navy, Rear Admiral Clifford A. Swanson asks that these members of the inactive Naval Reserve volunteer immediately for extended active duty. Medical and Dental officers in the ranks of Commander and below and Nurses in the ranks of Lieutenant and below will be accepted.

The recently authorized increase in the overall manpower strength of the Navy requires the services of additional Medical Department personnel to serve in the continental United States and overseas.

Members of the above reserve components volunteering for active duty should apply to the Chief of Naval Personnel, Navy Department, Washington 25, D. C.

Qualified civilian physicians, dentists and nurses may apply for active duty in the Medical, Dental and Nurse Corps of the U. S. Naval Reserve. Physicians and dentists will be commissioned in ranks up to and in-


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## EXPOSURE TO CARBON TETRACHLORIDE FUMES MAY CAUSE BLINDNESS

Three cases of blindness developing in industrial workers exposed to the fumes of carbon tetrachloride are reported in the March Archives of Industrial Hygiene and Occupational Medicine.

One man was employed in a plant making automatic razors, another as an electrician in an aluminum extraction plant, and a woman in a dress manufacturing establishment, according to Dr. Adelaide Ross Smith of the Division of Industrial Hygiene and Safety Standards of the New York State Department of Labor, New York.

In one patient, visual defects cleared almost completely after about a month of treatment, but in the remaining two only some sight had returned four and seven years after exposure, Dr. Smith says.

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VOL. 98 NO. 5

November, 1950

## Clinical Significance of the Femoral Hernia

## Limitations of Cytological Diagnosis from the Pathological Standpoint

(See page 5 for Table of Contents)

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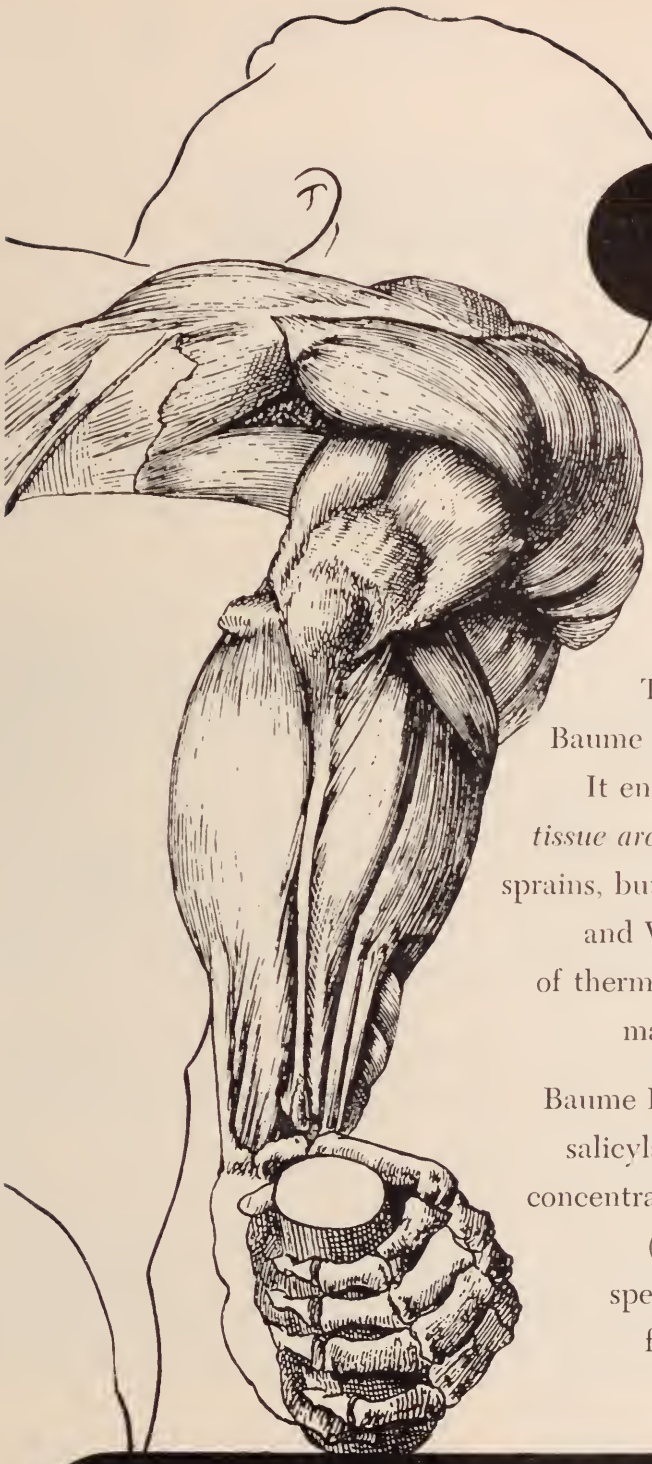
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1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

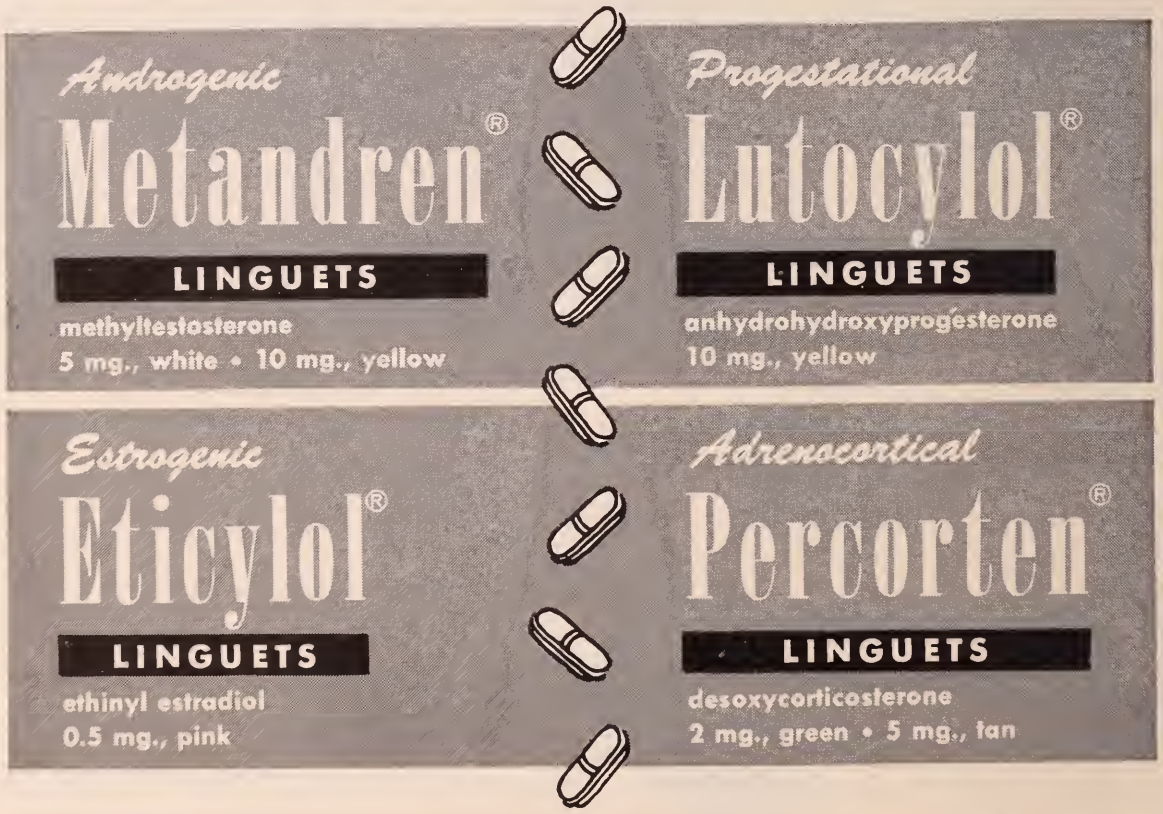
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Bull. Univ. California Med. Center, Nov. 1949

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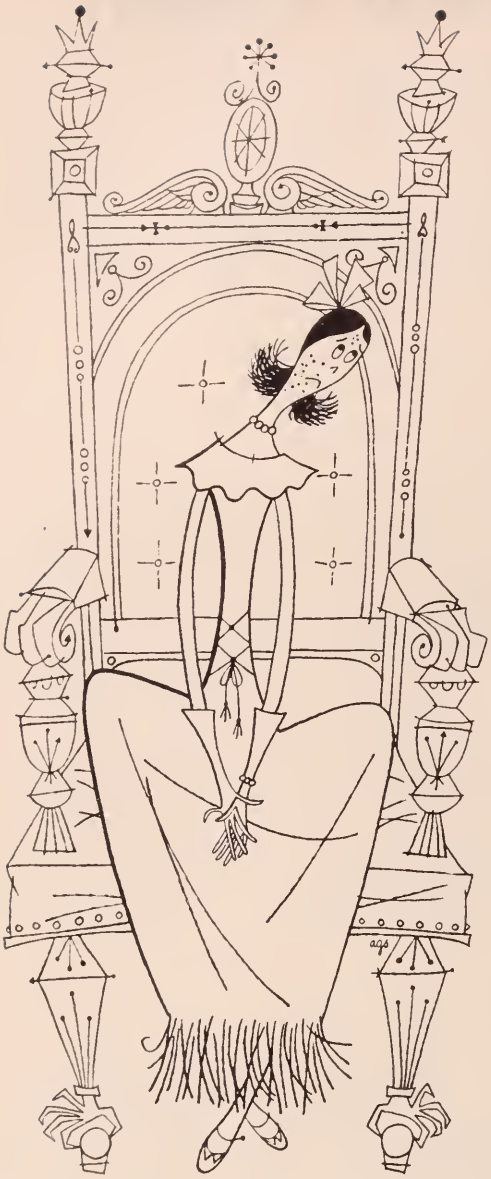
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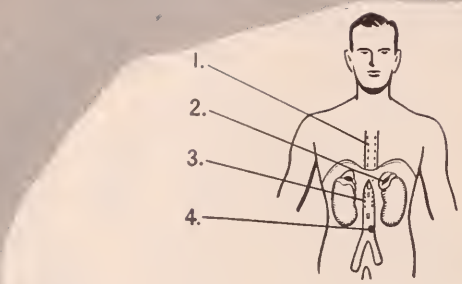



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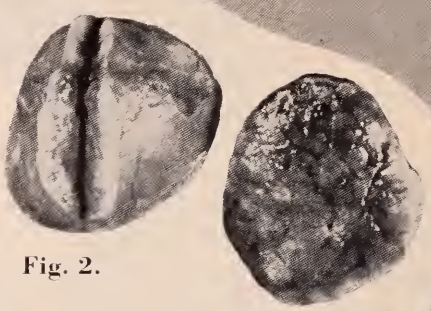


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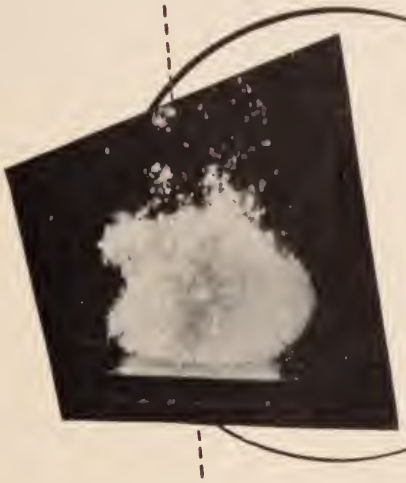
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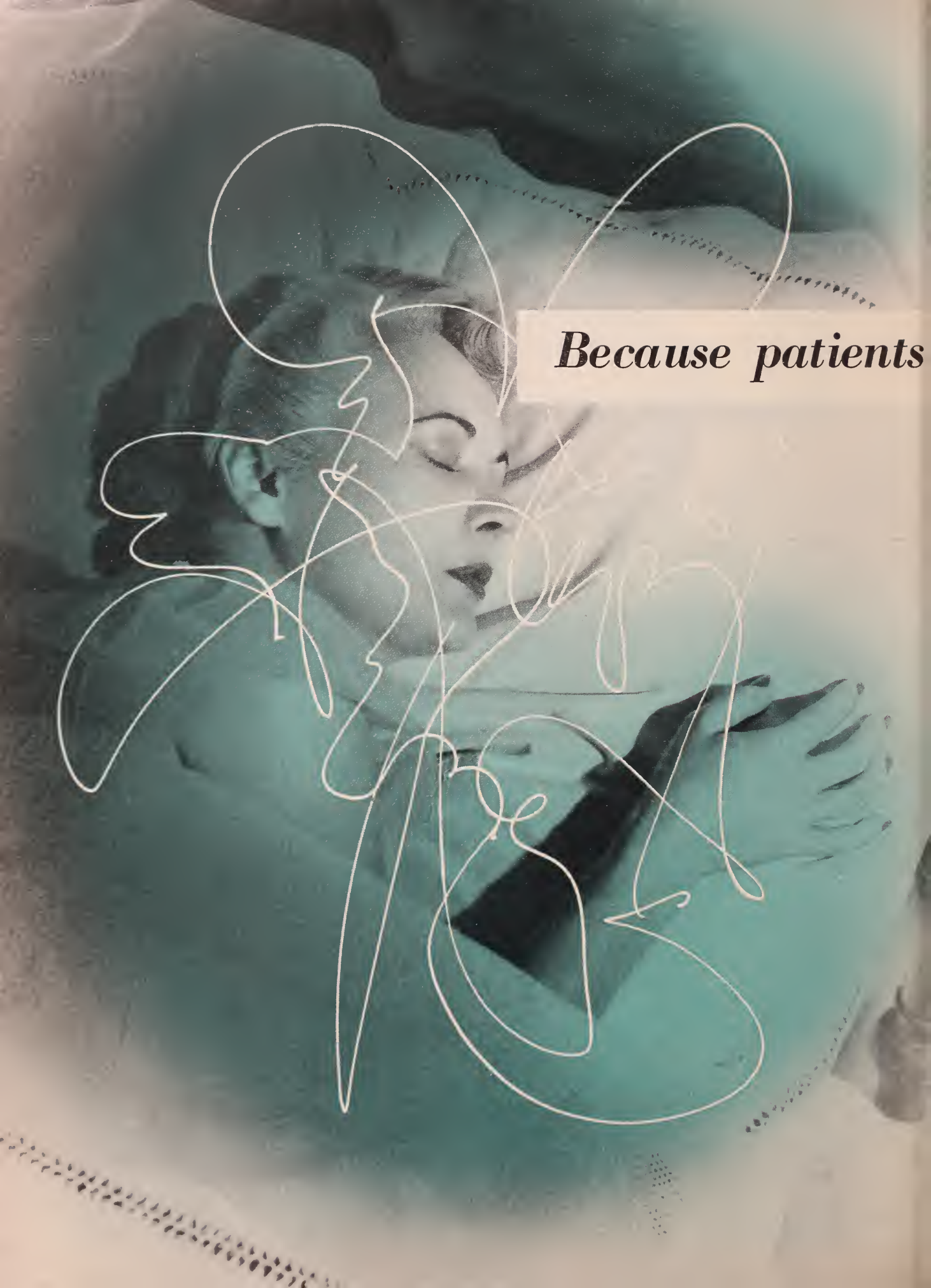
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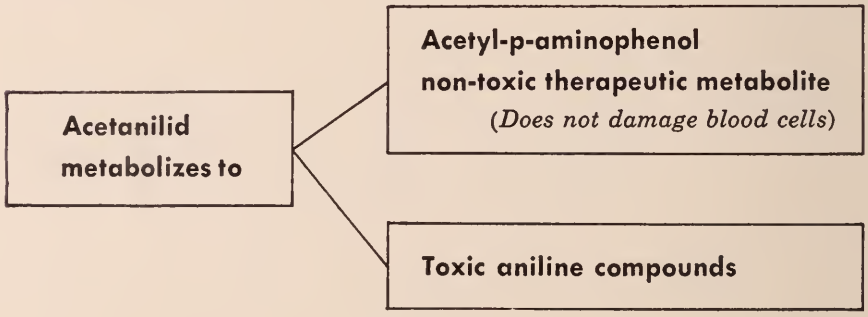
**When the threat of cardiac failure exists.** *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ¼ gr. Phenobarbital and 1½ grs. Theophylline.)

*Now offered to the medical profession for the first time*

# *A new analgesic compound containing acetyl-p-aminophenol*

*. . . the non-toxic therapeutic metabolite of acetanilid*

Long known as one of the most potent, rapid-acting analgesics, acetanilid has now been found to have a non-toxic therapeutic factor—*acetyl-p-aminophenol.* Studies at the Yale Laboratory of Applied Physiology and New York University School of Medicine show that *acetyl-p-aminophenol* has the high analgesic potency of acetanilid, without its toxicity. Unlike acetanilid and acetophenetidin compounds, *acetyl-p-aminophenol* does not damage blood cells, is safe even for chronic pain.




## TRIGESIC

Squibb *acetyl-p-aminophenol,* Aspirin and Caffeine Tablets

Trigesic offers all the advantages of acetanilid . . . none of the disadvantages . . . plus the benefits of aspirin and caffeine

Each tablet contains 0.125 Gm. *acetyl-p-aminophenol;* 0.23 Gm. aspirin and 0.03 Gm. caffeine. *Bottles of 36, 100 and 1,000.* Also available as TRIGESIC WITH CODEINE, containing, in addition, 16 mg. codeine phosphate. *Bottles of 100.*

**SQUIBB**

"TRIGESIC" IS A TRADEMARK OF E. R. SQUIBB & SONS

During pregnancy and lactation it is traditionally good practice to supplement the mother's diet with *iron*, *calcium*, *phosphorus*, and *vitamin D*. CADROSON tablets, a new Sharp & Dohme preparation, provide all these in proper strength and ratio, and another important mineral as well . . . *fluorine* . . . which appears to be efficient in the prophylaxis of dental caries. Moreover, fluorine-calcium supplementation has been reported valuable in aborting dental neuralgia and leg pains and cramps during pregnancy.

*Minerals for Mother*



# Cadroson®

SHARP & DOHME

Each six *Cadroson* tablets contain:

| | |
|---|---|
| *Calcium* | 1.5 Gm. |
| *Phosphorus* | 0.75 Gm. |
| *Fluorine* | 0.5 mg. |
| *Iron* | 15 mg. |
| *Vitamin D* | 1,000 U.S.P. Units |

CADROSON tablets are supplied in bottles of 100 and 1,000.
Sharp & Dohme, Philadelphia 1, Pa.

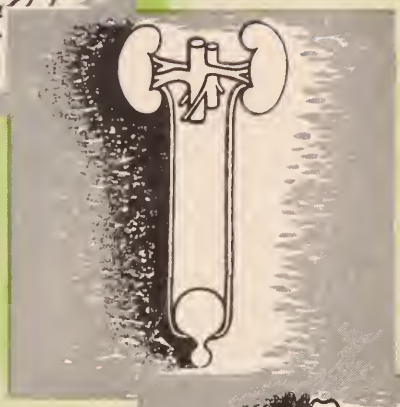
# TODAY'S WORD FOR SUPERIOR SPASMOLYSI

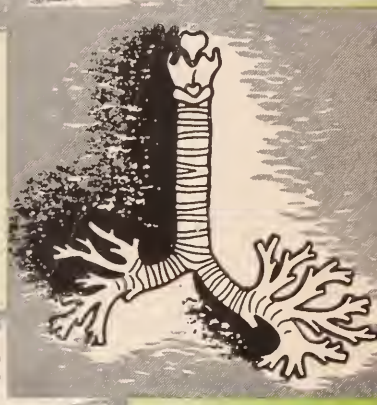




For relief of smooth muscle spasm, authoritative clinical data[1,2,3,4,5] attest the high efficacy of Donnatal 'Robins'—the spasmolytic employing *natural belladonna alkaloids* in precise, optimal ratios, together with a minimum phenobarbital content. Indeed, these facts are well established: (1) that Donnatal affords all the advantages of the natural belladonna alkaloids – yet is significantly non-toxic; (2) that it provides frequently required sedation – yet is entirely non-narcotic; (3) that it has marked pharmacologic potency – yet costs less; and (4) that its flexibility of dosage form – tablet, capsule and elixir – permits convenient, easy administration to patients of *all* ages. These facts make this product of Robins' research one of the safest and most dependable visceral spasmolytics available today.









**FORMULA:** Each tablet or capsule, and each 5 cc. (1 teaspoonful) of elixir contains:

| | |
|---|---|
| Hyoscyamine Sulfate | 0.1037 mg. |
| Atropine Sulfate | 0.0194 mg. |
| Hyoscine Hydrobromide | 0.0065 mg. |
| Phenobarbital (¼ gr.) | 16.2 mg. |

**DOSAGE:** *Tablets or capsules:* 1 to 2, three or more times daily (up to 9 tablets or capsules may be given within 24 hours without toxic effects).

**ELIXIR:** Infants: ½ teaspoonful two or three times daily as necessary. Children: one teaspoonful two or three times daily as needed. Adults: one or two teaspoonfuls three or four times daily.

**AVAILABLE:** Donnatal Tablets and Capsules in bottles of 100 and 500. Elixir in pints and gallons.

**INDICATIONS:** Spasm of stomach, intestines, uterus, bronchi, coronaries; Colic of gallbladder, bile ducts, ureter; Tenesmus of urinary bladder.

**REFERENCES:**


1. Kilstein, R.I.: Rev. Gastroenterol., 14:171, 1947.
2. Lee, L. W.: Neb. State Med. J., 34:59, 1949.
3. Morrissey, J. H.: J. Urol., 57:635, 1947.
4. Ricci, J. V.: Contributions from Dept. of Gynecology, City Hospital, New York, 1946, New York Medical College, New York, 1947.
5. Stephens, G. K.: J. Okla. State Med. Assn., 42:246, 1949.


**A. H. ROBINS CO., INC.** • **RICHMOND 20, VA.**

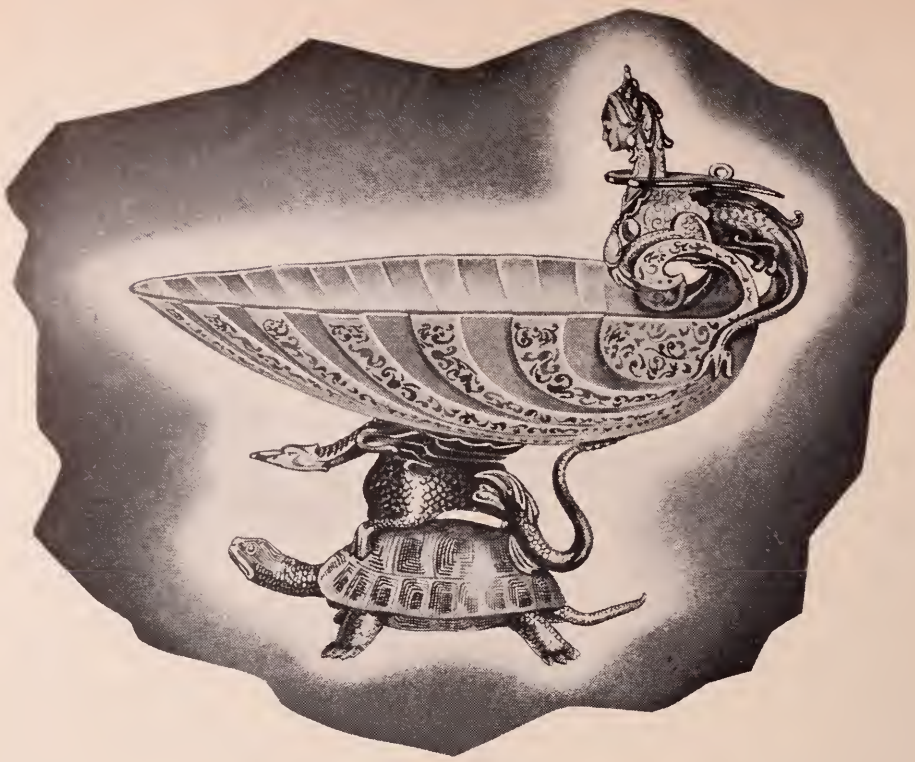
*Ethical Pharmaceuticals of Merit since 1878*




**For dependable spasmolysis, with natural belladonna alkalo**

℞ *Donnatal*

Robins



*Quality and Craftsmanship...*



# GELUSIL* *'Warner'*

Once in a long while a remedy is evolved which meets practically all of the medical requisites: effective, safe, and reliable. In the management of peptic ulcer or hyperacidic conditions, GELUSIL* 'Warner' by combining comparatively non-reactive aluminum hydroxide gel with magnesium trisilicate, provides the advantages of both.

**Prompt action** **Prompt relief**
**Prolonged action** **Prolonged relief**

without secondary acid rise, chloride depletion, or danger of alkalosis;

and, most important, there is practically no constipation.[1]

HOW AVAILABLE: GELUSIL* 'Warner,' the safe, effective and reliable antacid preparation is purely local and non-systemic in its action.

TABLETS—each containing magnesium trisilicate, 0.5 Gm (7.5 grains) and dried aluminum hydroxide gel, 0.25 Gm (4 grains): boxes of 50 and 100, and bottles of 1000 tablets.

LIQUID—magnesium trisilicate, 0.5 Gm (7.5 grains) and aluminum hydroxide, 0.25 Gm (4 grains) per 4 cc (1 teaspoonful): bottles of 6 and 12 fluidounces.

[1]Seley, S. A.: Medical Management of Pyloric Obstruction Resulting from Peptic Ulcer, *Am. J. Dig. Dis., 13*:238, 1946.

*T. M. Reg. U. S. Pat. Off.

## WILLIAM R. WARNER

Division of Warner-Hudnut, Inc.

New York • Los Angeles • St. Louis

# will reduction of serum cholesterol extend life?

by preventing atherosclerosis

"It is generally accepted that persistently high plasma cholesterol levels are associated with development of arteriosclerosis,"[1] a major cause of coronary thrombosis fatalities[2] and a "burning problem" in diabetes.[3]

Accumulating evidence shows that lipotropic therapy will reduce elevated blood cholesterol levels[4-7]. . . and even may "prevent or mitigate" cholesterol depositions in the intima of blood vessels in man and animals.

It has been reported[8] that in patients who have survived acute coronary occlusion, lipotropic therapy may significantly prolong life as compared to similar untreated groups.

**for complete lipotropic therapy**

## methischol capsules syrup

| suggested daily therapeutic dose of 9 capsules or 3 tablespoonfuls provides: | |
|---|---|
| Choline Dihydrogen Citrate | 2.5 Gm.* |
| dl-Methionine | 1.0 Gm. |
| Inositol | 0.75 Gm. |
| Liver fractions from 36 Gm. liver | |

*present in Methischol Syrup as 1.15 Gm. choline chloride.



**400% more cholesterol in coronary arteries in fatal thrombosis**

"The average cholesterol content of the coronary arteries in a group of patients who died from acute coronary artery thrombosis was four times as great as the average cholesterol content of the coronary arteries in a comparable group of control patients."[2]

*Write for samples and literature*


1. J.A.M.A. 143:858, 1950.
2. Morrison, L. M. and Johnson, K. D.: Amer. Heart J. 39:31, 1950.
3. Joslin, E. P.: Rev. Gastroent. 17:545, 1950.
4. Herrmann, G. R.: Exp. Med. & Surg. 5:149, May-Aug. 1947.
5. Leinwand, I. and Moore, D. H.: Amer. Heart J. 38:3, Sept. 1949.
6. Felch, W. C.: N. Y. Med. 5:16, Oct. 20, 1949.
7. Pomeranze, J. and Levine, V.: Rev. of Gastroent. 16:771, Oct. 1949.
8. Morrison, L. and Gonzalez, W. F.: Amer. Heart J. 38:471, Sept. 1949.



**u. s. vitamin corporation**

casimir funk laboratories, inc. (affiliate)

250 E. 43rd St. • New York 17, N. Y.

## now patients on low-sodium diets will enjoy their meals again

in
CONGESTIVE HEART FAILURE
TOXEMIAS OF PREGNANCY
HYPERTENSION

CO-SALT tastes and seasons food so much like sodium chloride that patients on low-sodium diets will hardly miss salt. They will cooperate more fully in adhering to your diet, be better nourished, keep intake of edema-causing sodium to a minimum.




# co-salt

the new and different sodium-free salt substitute

- tastes like salt
- looks like salt
- sprinkles like salt

Accepted for advertising in the Journal of the American Medical Association.



CO-SALT CONTAINS NO LITHIUM, NO SODIUM
...is not bitter, metallic, or disagreeable in taste.

CO-SALT is the only salt substitute to provide choline which blends with potassium and ammonium chlorides to produce a taste closely resembling that of sodium chloride — for use at the table or in cooking — will be a joy to low-sodium diet patients.

CO-SALT contains: Choline, Potassium Chloride, Ammonium Chloride and Tri-Calcium Phosphate.

Send for tasting samples and low-sodium diet charts.

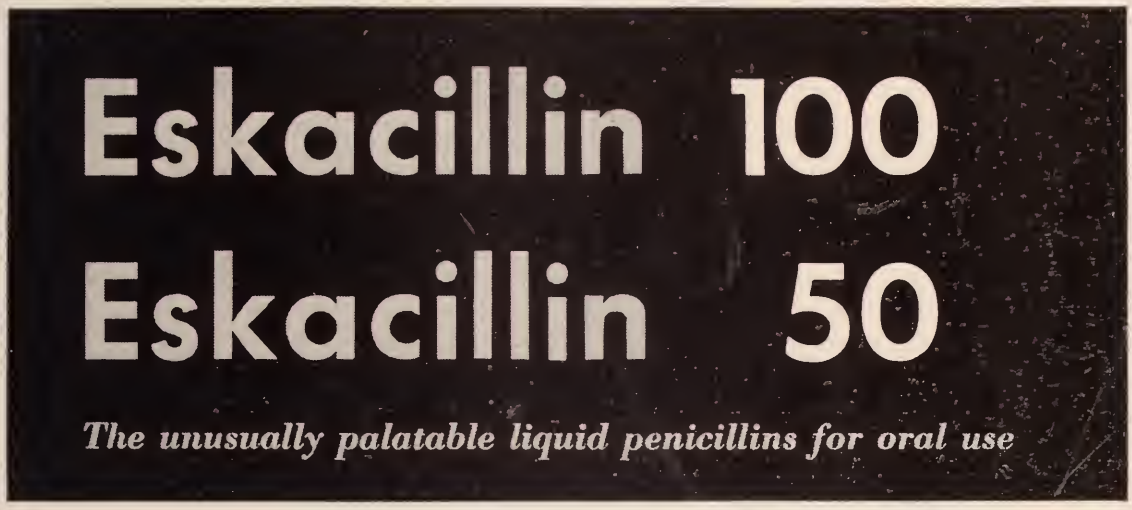
CASIMIR FUNK LABORATORIES, INC.
affiliate of U. S. VITAMIN CORPORATION
250 EAST 43rd ST., NEW YORK 17, N. Y.

*Today's trend is to* ***liquid***

# oral penicillin

"... it has been demonstrated repeatedly that the oral route is as effective as the parenteral route when adequate doses of penicillin are used."

Keefer, Chester S.: Am. J. Med. 7:216




In keeping with today's trend to oral penicillin, S.K.F. now offers, for your convenience, Eskacillin in 2 strengths: 'Eskacillin 100', containing 100,000 units of penicillin per 5 cc. (one teaspoonful). 'Eskacillin 50', containing 50,000 units of penicillin per 5 cc. (one teaspoonful).

**Among the many indications are:**

- Acute sinusitis
- Bronchitis
- Tonsillitis
- Otitis media
- Pneumonia
- Cellulitis
- Gonorrhea
- Certain skin infections

*Smith, Kline & French Laboratories, Philadelphia*

'Eskacillin' T.M. Reg. U.S. Pat. Off.

# "In general, symptomatic improvement [of menopausal symptoms] was striking within 7 to 14 days after treatment..." with "Premarin."

*Gray, L.: J. Clin. Endocrinol. 3:92 (Feb.) 1943.*

Many clinicians have found that "Premarin" therapy usually brings about prompt relief of distressing menopausal symptoms. Furthermore, symptomatic improvement is followed by a gratifying sense of well-being in a majority of cases. This is the "plus" in "Premarin" therapy which tends to quickly restore the patient's normal mental outlook.

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

Ayerst®

"PREMARIN"®

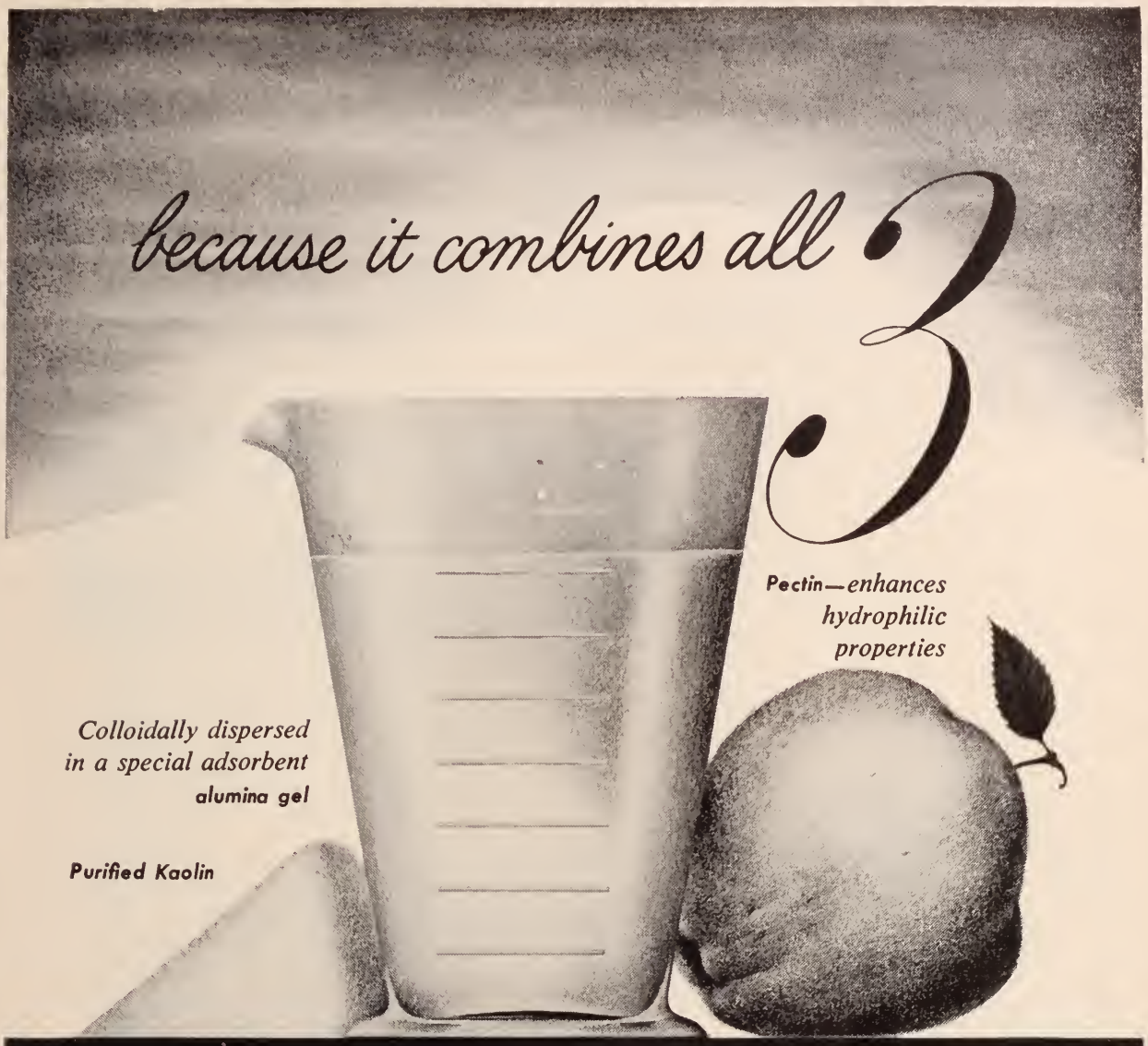
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Estrogenic Substances (water-soluble) also known as Conjugated Estrogens (equine)*

Ayerst, McKenna & Harrison Limited

*22 East 40th Street, New York 16, N. Y.*

5013




# KAOMAGMA® with PECTIN is effective in Control of Diarrhea

Relief is quick . . . Kaomagma with Pectin soothes and protects inflamed intestinal mucosa. Cramps and distention are promptly relieved.

**Consolidates stools . . . checks fluid loss . . . restores patient's comfort.**

*Bottles of 12 fl. oz.*

Wyeth®

WYETH Incorporated, Philadelphia 3, Pa.

# All you need in a Penicillin Preparation

# Bi-Pen

*Procaine Penicillin and*
*Buffered Crystalline Penicillin*
*For Aqueous Injection*

### *RAPID ABSORPTION*

The 100,000 units of crystalline penicillin G potassium in each dose of Bi-Pen is rapidly absorbed, leading to a significant, initially high plasma penicillin level. Thus, in the initial stages of therapy, the specific action of penicillin is made available immediately.

### *PROLONGED LEVELS*

Slower absorption of the crystalline procaine penicillin G (300,000 units per dose) produces detectable levels for at least 24 hours following each injection. Once-a-day administration usually suffices.

### *EASILY PREPARED*

The addition of Water for Injection U.S.P. is all that is necessary to prepare Bi-Pen for injection. The insoluble procaine penicillin salt goes into suspension readily, forming a well dispersed, homogeneous mixture.

### *READILY INJECTED*

Bi-Pen is free-flowing and is readily aspirated into the syringe and injected into the tissues. It should be given intramuscularly only. Average dose, 1 cc. (400,000 units) daily, but this quantity may be doubled if indicated.

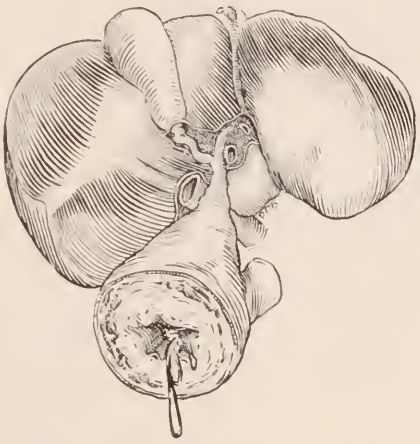
Bi-Pen is supplied in three package sizes: (1), 5 dose rubber-capped vials containing two million units, (2), single dose vials (400,000 units) packaged singly, and (3), single dose vials in boxes of 50.

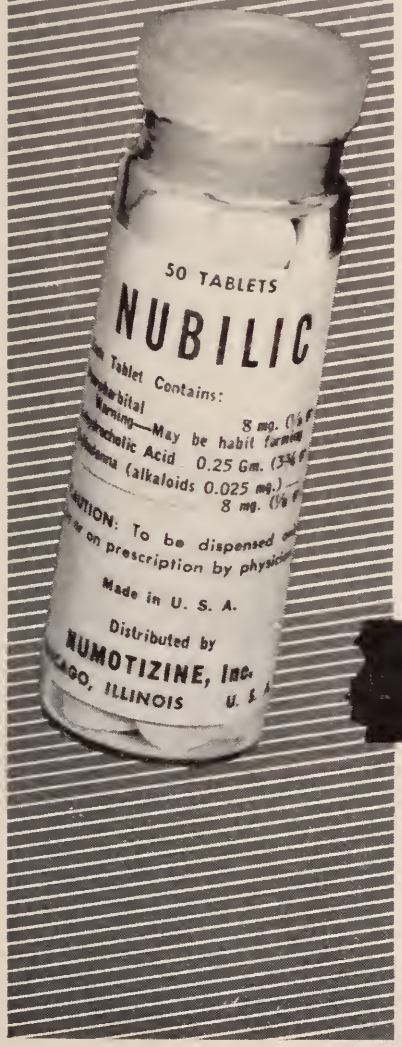
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A DIVISION OF COMMERCIAL SOLVENTS CORPORATION, 17 EAST 42ND STREET, NEW YORK 17, NEW YORK

# *Physiologic*

## IN GALLBLADDER MANAGEMENT






**NUBILIC** represents the modern trend in the management of inflamed and congested gallbladder and bile ducts.

**NUBILIC** contains dehydrocholic acid, an efficient hydrocholeretic agent which thins the liver bile and flushes the biliary passages.

**NUBILIC** contains belladonna, which encourages free drainage and relaxes the sphincter of Oddi. This action is further enhanced by the central sedation of phenobarbital.

# NUBILIC

Each Nubilic Tablet contains:

| | |
|---|---|
| Dehydrocholic acid | 0.25 Gm. (3¾ gr.) |
| Phenobarbital | 8 mg. (⅛ gr.) |
| Belladonna | 8 mg. (⅛ gr.) |

Bottles of 25, 50 and 100 tablets

## NUMOTIZINE, Inc.

900 N. Franklin Street • Chicago 10, Illinois, U.S.A.


HEALING
Cuts
Abrasions
Burns
Scalds
Sunburn
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Frostbite
The Ointment of Multiple Uses
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SOOTHING
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Chafing
Dry Skin
Chapping
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PROTECTING
Cracked Nipples
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Routine Breast Care
.....rapid epithelial repair, healthy granulation
.....retards scar tissue formation
.....particularly helpful in slow healing wounds
.....pleasantly fragrant
.....in 1½ oz. tubes, and in 8 oz. and 16 oz. jars
White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

# in obesity...

℞ Tablet of concentrated willpower

a.c.



**Meal-to-meal adherence to restricted reducing diets is made much easier by Desyphed. A material contribution to the success of a weight reduction program is achieved by:**

1. Blunting the patient's hunger and appetite
2. Producing a feeling of well being
3. Helping to overcome depressive states which frequently are responsible for overeating
4. Increasing desire for activity (ambition)
5. Increasing physical activity (therewith indirectly increasing metabolism)

Desyphed is also a valuable agent to counteract drug drowsiness (antihistaminics, sedatives), to overcome mild depressive states and narcolepsy, and to counteract hypotension.

# desyphed®

BRAND OF METHAMPHETAMINE HYDROCHLORIDE

*prolonged action...*
*effective in small dosage...*

**dosage:** The average adult dose of Desyphed for the treatment of obesity is one 2.5 mg. tablet one hour before breakfast and lunch daily. Another tablet may be taken in the middle of the afternoon if needed, provided it does not cause insomnia.

Available in tablets of 2.5 mg., bottles of 100 tablets.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Desyphed, trademark reg. U .S. & Canada

# MONITAN



## THE "*Proxy-Emulsifier*" FOR *Fat-Starved* PATIENTS

Whatever the causes of steatorrhea — be it sprue or following subtotal gastrectomy — high fecal fat excretion can rapidly lead to a cachectic, fat-starved patient.

Monitan, a highly efficient fat emulsifier, enables these patients to better absorb and utilize essential fats, lipids and oil-soluble vitamins. Monitan lowers fecal fat excretion by reducing the size of the fat droplets — making them more easily assimilable.

Monitan is the first palatable preparation offering Sorbitan Monooleate Polyoxyethylene Derivatives in liquid form. Each teaspoonful (5 cc.) of Monitan provides 1.5 Grams of this substance (P.S.M.). It is orange flavored and easily administered to infants, children and the aged. Literature available.

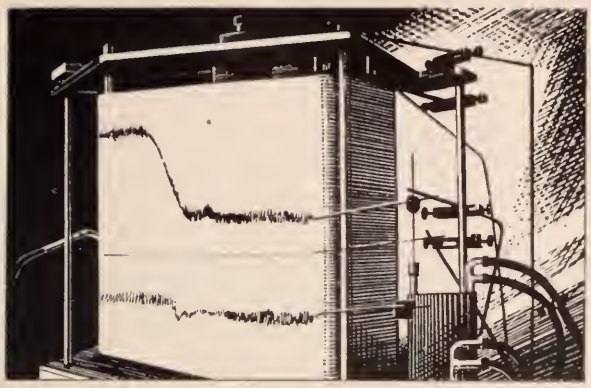
MONITAN

In 12 oz. bottles. Dosage: adults 1 to 2 teaspoonfuls three times daily with meals.

I.V.C.®

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*now*



.....a Veratrum extract biologically standardized for hypotensive potency in mammals

# VERILOID*

*Product of Riker Research*

*In every form of hypertension, a new and more efficacious approach*

**UNIFORM POTENCY.** Careful biologic standardization of Veriloid in dogs, *using drop in blood pressure as the end point*, insures uniformity in hypotensive potency. Veriloid makes available for the first time the active ester alkaloids of Veratrum viride in rigidly assayed form, making for greater accuracy in the management of the hypertensive patient.

**UNIFORM THERAPEUTIC EFFECT.** Veriloid is uniform in its therapeutic effect—from bottle to bottle, from batch to batch. While individualization of dosage is essential for maximum therapeutic benefit, in the majority of patients the average dose of 2.0 to 5.0 mg. three or four times daily, after meals and at bedtime, leads to prompt objective and subjective improvement. Adjustment of dosage thereafter to suit the specific needs of the patient is accomplished in two to three weeks. Therapy can then be maintained as long as necessary since tolerance to Veriloid is not likely to develop.

*Veriloid is available on prescription only through all pharmacies in tablets containing 1.0 mg., in bottles of 100, 200, 500, and 1000. Literature on request.*

*Trade Mark Riker Laboratories, Inc.

RIKER LABORATORIES, INC., 8480 BEVERLY BLVD., LOS ANGELES 48, CALIF.

# how the Paredrine in Par-Pen helps its penicillin fight intranasal infection

Council-accepted Paredrine Hydrobromide produces rapid and prolonged shrinkage of nasal mucosa. The nasal passages are opened so that the penicillin can "get through" to the infected areas. Bacteriostasis is thereby facilitated.

Paredrine does not break down the penicillin. Par-Pen remains at full therapeutic potency for an entire week—even when kept at room temperature.

Par-Pen contains crystalline potassium penicillin G, 5000 units per cc.; Paredrine Hydrobromide (hydroxyamphetamine hydrobromide, S.K.F.), 1%; in a specially buffered isotonic aqueous solution. Packaged in ½ fl. oz. bottles.

*Smith, Kline & French Laboratories, Philadelphia*



# Par-Pen

**the penicillin-vasoconstrictor for intranasal use**

'Paredrine' & 'Par-Pen' T.M. Reg. U.S. Pat. Off.

*a* ***critical evaluation***

*of drugs for treating*

***urinary tract infections***

*it has been noted that:*



# SULAMYD®

(Sulfacetimide)

"combines the features of good antibacterial activity, low toxicity, and rapid renal elimination resulting in high urinary level. . . . Sulfacetimide . . . has the advantage of high solubility even in the physiological acid range of the urine, thereby minimizing almost to a negligible point the danger of concrement formation. . . ."[1] Because of its wide antibacterial range it may be preferable to penicillin and streptomycin.[2] It is well tolerated and remarkably free from side effects.[3]

**DOSAGE:** Therapeutic: 2 tablets t.i.d. for 10 days.
Prophylactic: 1 tablet t.i.d.

**SULAMYD** Tablets 0.5 Gm. in bottles of 100 and 1000 tablets.


1. Nesbit, R. M., and Glickman, S. I.: J. Michigan State M. Soc. *46*:664, 1947.
2. Dodson, A. I.: West Virginia M.J. *45*:1, 1949.
3. Seneca, H.; Henderson, E., and Harvey, M.: J. Urol. *61*:1105, 1949.


SULAMYD

SCHERING

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# This LIFE-LIKE Bardach-Schoene VACULIMB* ELIMINATES Shoulder or Waist SUSPENSION HARNESS

Action is instantly and accurately graduated in response to the degree of Stump operation by the patient.

A normal "feel" or reaction of the Stump allows the patient to sense the degree of application or release necessary to locomotion.

The controlling force of the Stump is rapidly transmitted to the VACULIMB, because of the close contact . . . no lost motion.



*The Stump should be dressed with Stockinet before using VACULIMB*



*Then Stump is placed in socket of VACULIMB in comfortable position*



*Next, Stockinet is drawn off Stump through Valve opening of VACULIMB . . .*



*Then adjustable Automatic Valve is inserted to seal opening to VACULIMB. . .*



*Finally, excess air is released by bearing body weight on VACULIMB.*

TO YOU, OUR FRIENDS, who have helped build this organization by your patronage, and to those whom we hope to serve in the future, we submit this most important development in the field of prosthetic appliances . . . The Bardach-Schoene VACULIMB!

While our VACULIMB is new to America's civilian use, it has a record of many years of successful use by thousands of amputees in Europe, in spite of extremely unfavorable manufacturing conditions. Because of this unique situation, the VACULIMB is undoubtedy the best "new" prosthesis ever announced to the Medical Profession, for the comfort and welfare of amputees.

An expert technician with long experience, trained in our organization in prosthetic work, will call at your convenience to demonstrate by actual test the amazing simplicity and accuracy of the new Barbach-Schoene VACULIMB . . . proving that it is sufficiently simple in operation for the amputee to justify its recommendation.

Our profession is like any other profession . . . progress and success in serving depends on the simple fundamental rule that each patient must be satisfied . . . our service is rendered throughout the life of the patient.

Close contact during many years with the Medical Profession, interested in the field of prosthetics, has been of great aid in gathering a wealth of important data, which is distributed by mail or direct contact upon request.

We welcome the opportunity to consult with the Medical Profession or Hospital concerning further details of our specialized service.

**NO EXTERNAL LEATHER STRAPS OR MECHANICAL MOVING PARTS TOUCH THE BODY**

# Bardach-Schoene Company, Inc.

**102 South Canal Street, CHICAGO 6, ILLINOIS**

*VACULIMB—Trade Mark Reg. U. S. Pat. Off.

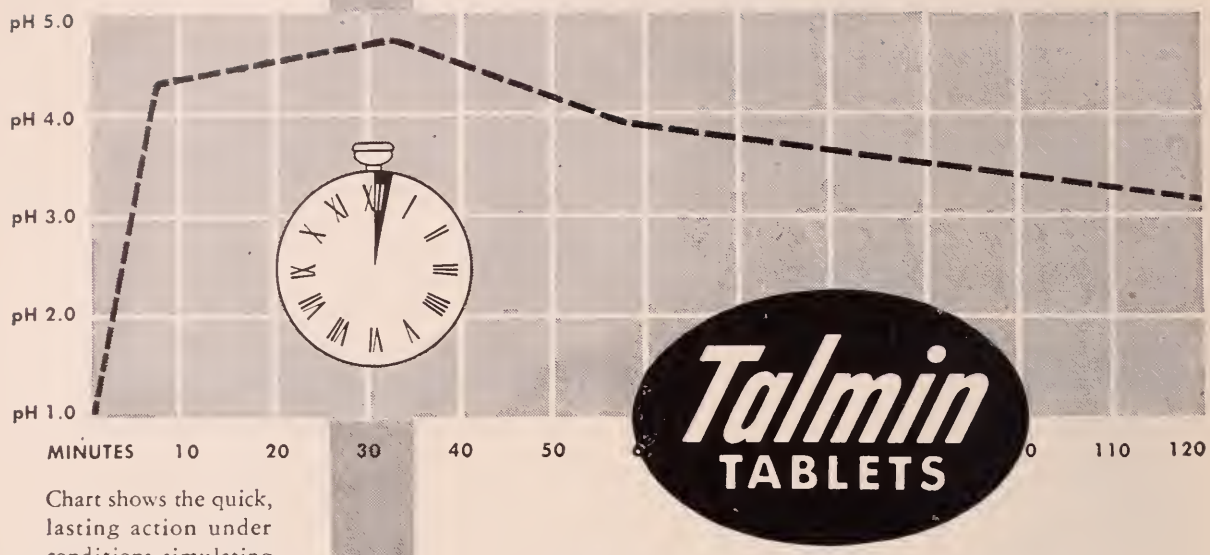



Chart shows the quick, lasting action under conditions simulating those of the stomach.

**Talmin TABLETS**

FOR

## Prompt, Prolonged Action* in treatment of peptic ulcer and gastric hyperacidity

Talmin will raise the pH of the gastric contents to approximately pH 4.0 within 2 minutes, and maintain it above pH 3.0 for 120 minutes.

Each tablet contains Dihydroxy Aluminum Aminoacetate 5 gr., Magnesium Carbonate 2 gr. Also available: Talmin Compound Tablets, containing per tablet: Above ingredients, plus Phenobarbital ¼ gr., and Extract of Belladonna ⅛ gr.

* **OTHER CHARACTERISTICS**

- Quick solubility
- Pleasant taste
- High acid buffer capacity
- Non-alkalinizing
- No acid rebound
- No digestive disturbance
- Low aluminum content
- Non-constipating

AT MOST PHARMACIES
In 100's Individually Wrapped; 500's for Dispensing.
ADVERTISED ONLY TO THE PROFESSION.

*For further information and samples, write*

# S. M. Pharmaceuticals

Division of Special Milk Products, Inc.
Los Angeles 64, California • Since 1934

We also supply Meyenberg Evaporated Goat Milk: Hi-Pro: SolFerr: TabFerr: SM Multi-Vitamins: Sol Ad: Sol C: SolDex

# cough control plus...




BENYLIN EXPECTORANT relieves harassing cough safely and rapidly; and it alleviates nasal stuffiness, sneezing, lacrimation and bronchial congestion by combining well-established antitussive agents with Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis).

# BENYLIN Expectorant

Trade Mark

BENYLIN EXPECTORANT
contains in each fluid ounce:

| | |
|---|---|
| Benadryl hydrochloride | 80 mg. |
| Ammonium chloride | 12 gr. |
| Sodium citrate | 5 gr. |
| Chloroform | 2 gr. |
| Menthol | 1/10 gr. |

BENYLIN EXPECTORANT is available in 16 oz. and gallon bottles.

- ***for promotion of drainage:*** BENYLIN EXPECTORANT liquefies and aids removal of irritating and infection-laden bronchial secretions.
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***dosage:*** One to two teaspoonfuls every two to three hours. Children, ½ to one teaspoonful every three hours.

Supplied in a pleasantly-flavored demulcent vehicle which is acceptable to patients of all age groups.

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'ESKACILLIN-SULFAS' is for the prevention and treatment of infections caused by organisms sensitive to the action of penicillin or the sulfonamides.

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Aureomycin has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, acute brucellosis, common infections of the uterus and adnexa, resistant gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, lymphogranuloma venereum, psittacosis (parrot fever), Q fever, rickettsialpox, Rocky Mountain spotted fever, subacute bacterial endocarditis resistant to penicillin, surgical infections, tick-bite fever (African), tularemia and typhus.

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"Not often do either globin insulin or a 2:1 mixture require supplementary use of regular insulin. Fully 80% of all severe diabetics can be balanced satisfactorily with one of them."[2]

1. *Reeb, B. B., Rohr, J. R., and Colwell, A. R.: Proc. House Staff Dept. Med., Wesley Memorial Hospital, Chicago, Ill. Feb. 6, 1948.*

2. *Rohr, J. H., and Colwell, A. R., Proc. Amer. Diabetes Assn. 8:37, 1948.*

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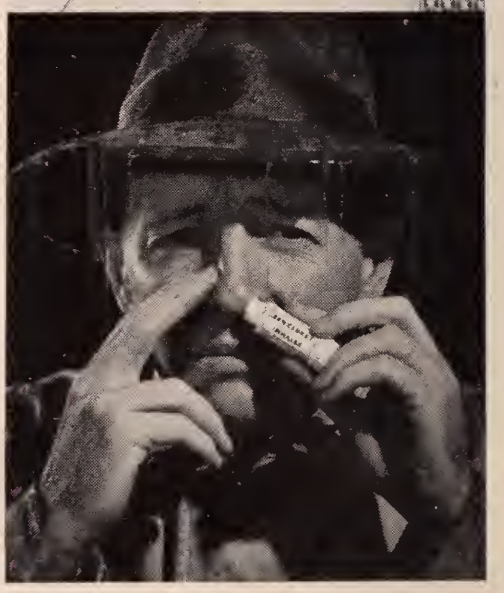
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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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## 1951 MARCH OF DIMES

The National Foundation for Infantile Paralysis is now facing the most acute period in its history. All chapters in the State of Illinois are realizing that the situation is definitely critical.

The severe epidemics in Illinois, lasting from 1945 through the present year, have thrown a heavy burden on the 102 National Foundation Chapters. Last year's severe epidemic left many seriously paralyzed patients who are still receiving medical care, both in and out of hospitals. The financial burden on the various Illinois chapters has been the greatest in the history of the organization.

It has been necessary for most of the chapters in Illinois throughout the five year period, to lean rather heavily upon the epidemic aid funds from the national headquarters. Inasmuch as the only means of revenue these chapters have is the March of Dimes, it is hoped that the coming January, 1951 drive will provide sufficient funds to carry on the important three-fold program of medical care, research and education.

Allied with the Foundation in their work to protect residents of the state, various organizations have an opportunity to take the lead in the 1951 campaign.

Auxiliaries may assist the March of Dimes by supporting the drive in the various communities and by adopting the campaign as a public service project for January. Individual members of the auxiliaries throughout the state, may provide valuable help if there there is not an organized auxiliary in the county. Assistance may be given in the field of publicity, solicitation of funds, development of special events, and other critically needed services. Any organized assistance will be appreciated.

The people of Illinois should go "all out" in this campaign; all civic minded organizations should participate and contribute time and money to make the MARCH OF DIMES for 1951 a success.

## COOPERATION WITH CIVILIAN DEFENSE ORGANIZATIONS

A note of warning appeared recently in the New York State Journal of Medicine* relative to the growing menace of Communism.

Dr. Vannevar Bush, one of this nation's leading atomic scientists and never one to speak at random, recently gave an ominous interview on enemy plans respecting the United States. A direct Soviet punch at this country in the near future, Dr. Bush thinks, is not likely. He believes the Kremlin will wait until it has a good-sized stockpile of atom bombs. Then, he

*N.Y. State J. of Medicine — Oct. 15, 1950. p. 2401.

forecasts, a mass atomic raid on the nation's key points, with Washington and New York as the main targets. The Soviet aim would be to strike us a rapid series of blows from which we could not recover in time to keep Russia from taking us over for keeps — what was left of us, that is.

Dr. Bush sees no sense in trying to negotiate a treaty with the Kremlin to outlaw the atom bomb. You might just as well, he says, conclude a treaty with a wolf. The Communist overlords of Russia are as cold, calculating, and ruthless as any group of alleged humans ever seen in the world, and the United States is tops on their hate list.

This statement from one of our leading atomic scientists is certain to set a lot of Americans thinking afresh of the advisability of a preventive war — meaning to get in the first punch at Russia with our own atom bombs and the planes that can deliver them. Of such planes we have quite a number. Indeed, the current issue of the *Pilot,* official publication of the Roman Catholic Archdiocese of Boston, discusses preventive wars, and says such a thing may be necessary and entirely moral if and when we fail in all possible efforts to talk the Kremlin out of its world-conquest ideas.

How this argument will finally wind up, nobody can foresee just now. But it would seem sensible for Americans everywhere, and particularly those in the big city areas, to get going on civilian defense programs in earnest.

This is just another reason why we must redouble our efforts to strengthen the homefront. Illinois already has made a strong bid to be a leader in civilian defense and many States are looking to us for guidance. The physician from Illinois should realize that he lives in a strategic area surrounded by such likely targets as Chicago, Rock Island, Moline, Peoria, St. Louis and Gary. Furthermore, airplanes do not follow the traditional sea-lanes and a glance at the globe will show that Illinois is in an excellent spot for an attack from the Soviet Union. It is no wonder that we, above all, should be on the alert. We must cooperate with civilian defense organizations because in case of an attack the problem of providing hospital care and medical services is one that will require the utilization of all medical manpower of the State.

## AUREOMYCIN AND AMEBIASIS

The use of aureomycin in the treatment of amebic dysentery marks another milestone in the history of that disease. During the last few months many favorable reports have appeared in the literature to justify these conclusions.

In a series of 8 patients who were treated by Most[1], 7 have remained free from the parasite long after the drug was administered. He gave them 20 grams of aureomycin by mouth during a 10 day period. McVay[2] and his colleagues at the University of Tennessee College of Medicine treated 11 cases successfully with no recurrence of symptoms. Hughes[3] had a similar experience with 38 cases. He considered the effect of aureomycin as outstanding because it gives the most consistent symptomatic relief of all the amebacides and destroys the E. histolytica and most of the secondary invaders. In the series of cases reported by Hughes, practically all of the patients had repeated ineffective courses of carbarsone, diodoquin, emetine and chiniofon. In other words, they had had difficulty in eradicating the disease in this group of patients. A good response followed the administration of aureomycin in 27 of the 38 patients. Two weeks after the last dose of aureomycin they were symptom free and reported as having 5 negative stool examinations following saline purgation.

These reports are encouraging but we should not dispense entirely with conventional therapy. Discussion has it that best results are obtained when these products are used after aureomycin has been administered. This is worth considering because it is possible that by this method a higher percentage of cures will be obtained.

1. Most, Harry: Aureomycin and Amebiasis. Bull. N. Y. Acad. of Med. 25:717, November, 1949.
2. McVay, L. V., Laird, R. L., and Spruit, D. H.: A Premininary Report of the Successful Treatment of Amebiasis with Aureomycin. Science, 109:590, June 10, 1949.
3. Hughes, J. D.: Treatment of Amebiasis with Aureomycin. JAMA, 142:1052, April 8, 1950.

## MEDICAL PUBLIC RELATIONS CONFERENCE

Terming the county "the key area in which the main public relations job of the medical profession must be done," Dr. George F. Lull, Secretary and General Manager of the American Medical Association, has announced plans for the Third Annual Medical Public Relations Conference.

The 1950 Conference is set for December 3

and 4 in Cleveland — just prior to the Clinical Session of the American Medical Association. It will concentrate on county society programs aimed at increasing community goodwill toward the medical profession.

In attendance at the two-day session will be some 300 M.D. chairmen of state and county medical society public relations committees, society executive secretaries and public relations directors, officers of the American Medical Association Woman's Auxiliary and key representatives of allied health organizations.

The program schedule calls for four work sessions, two noon sessions and an evening session. All activities will be at the Hotel Statler.

The opening work session on Sunday, December 3, will take up the important "groundwork for a successful public relations program." On the docket will be discussions on organizing public relations committees, financing the program, techniques for finding out what public relations work is needed, program planning and ways to build support among society members.

Work sessions on Monday, December 4, will include a timely summary of "county societies and the legislative scene," a series of brief reports on specific worthwhile county public relations activities, and an open forum period during which conferees will divide into three groups to swap ideas with representatives from similar-sized communities.

Appearing at the "legislative" session will be Dr. Dwight H. Murray, A.M.A. Trustee and Chairman of the Committee on Legislation and Dr. Joseph S. Lawrence, Director of A.M.A. Washington Office.

The "activities with a purpose," session will show how county public relations projects have improved community feelings towards doctors. Among the projects to be discussed are "community-minded doctors," "a doctor for every family," "working with other professions," "the doctor and civilian defense," and "let the doctor speak."

On Monday afternoon three discussion groups will be formed to take up medical public relations problems in small communities, medium-sized communities and metropolitan areas. Each group will attempt to work out basic ideas that will be useful to other county societies embarking on public relations campaigns.

Sunday noon, Dr. John W. Cline, President-elect of the American Medical Association, will keynote the Conference with an address on "Serve Your Nation Through Better Public Relations." Speaker at the Monday noon session will be R. W. Mills, secretary or the Fond du Lac, Wisconsin, Association of Commerce. His topic is: "The American Way of Life."

Mid-point of the idea-packed Public Relations Conference will be the annual Conference Dinner Sunday evening. Sharing the speaker's platform will be A.M.A. President, Dr. Elmer L. Henderson, and a nationally prominent man outside the medical field. In addition, the program will feature cartoonist Marvin Bradley, one of the creators of the comic strip, "Rex Morgan, M.D."

As a supplement to the regular Conference sessions, two special visual aid demonstrations have been scheduled. One will be a screening of the new Louis de Rochemont film, "M.D. — the U.S. Doctor." The other will be a demonstration of a television package show being produced by the Bureau of Health Education for use by state and county societies.

# MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Maloney, Roland R. Cross, Alfred P. Bay, Frederick T. Jung.



# Application of Radio-Isotopes as a Career for Physicians

This editorial intends to explore the medical application of isotopes and to answer the question, "Will the use of isotopes develop a new type of specialist?"

The Atomic Energy Commission produces radioactive isotopes which it sells to individuals and institutions able to receive, handle and use these materials safely and wisely. The materials are rendered radioactive by exposure to the neutron flux in the nuclear reaction or "pile" at the National Laboratory at Oak Ridge. A few commercial companies process the radioactive substances into pharmaceutical form suitable for use in patients. This entire program is now in development under the able leadership of Dr. Paul Aebersold, a physicist, who heads the Isotope Division at Oak Ridge. It in no sense deals with any secret information or to the production or use of any weapon. The program deals with the technical and research applications of radio-isotopes.

The physicist, the physical chemist and the chemist are the leaders. These men are trained in nuclear physics which was unknown material when most of us were in college. They are skilled in precision, in measurements of radioactivity and in mathematics. In short they are specialists in the techniques of handling radioactive substances and in tracing these substances by various detecting devices. A few physicians have attempted to acquire a Ph. D. degree in one of these basic fields after finishing the M.D. degree. This effort, an exceedingly difficult task, appears unwise. Why should the physician compete—why not cooperate and work with the physicist and the physical chemist? The design of equipment, basic plans for its use, and review of technical procedures for errors, etc., should be in the hands of the physicist, with rare exceptions.

Isotopes are slowly acquiring uses in industry. Guages to measure thickness of metal or of paper on plastic are now available. There is no health hazard in the use of such devices. Anyhow the "health physics" group has a prior hold on control of radiation hazards where they do exist. "Health physics" deals with measurement of radiation exposure in laboratories and control of radio-active wastes. Routinely they compute and

check the shielding required for a process, the film badge and other dosimeter results, search for contamination, safeguard from spills, etc. They deal with design of laboratories and thus specialize in prevention of trouble.

The physiologist has already learned to use radioactivity as a tracer in minute quantities. A model of such procedure was the work with radioiodine by Hamilton and Soley in 1939* This material was made in a cyclotron. Although $I^{131}$ was available in only minute quantities these men made observations which have been confirmed by everyone using $I^{131}$ since then. In diagnosis of hyperthyroidism and cancer of the thyroid $I^{131}$ has an assured place. $P^{32}$ has a similar role for treatment in polycythemia. Radioactive gold and a few other radioactive elements have limited therapeutic possibilities. Sources of radiation resembling that from radium are now available such as radiocobalt. In placques and applicators this is now available for surface use. Internal dosage with isotopes for cancer seems of doubtful value.

In each application of an isotope it seems the user is already a specialist in his own field. He then learns enough about radioactivity to use it in his own field. Perhaps he will work with a physicist or a chemist. The Atomic Energy Commission operates an Institute for Nuclear Studies. With headquarters in Oak Ridge it cooperates with a number of southern universities in training graduate students. This agency operates a school in techniques. Short and long term courses may be had. A similar set up is available at the Argonne Laboratory.

From the foregoing it is apparent that a considerable number of physicians are going to know a great deal about the use of radioactive isotopes in research, in the study of physiology and in such therapeutic procedures that may be developed in the future, in addition to the use of phosphorus and iodine and the external applications of radioactive materials. However, none of this constitutes a new specialty. Each phase is the application of a new technique to an established specialty—physiology, internal medicine and radiology. In none of these fields will the physician be able fully to replace the physicist and of course he will not attempt to replace technicians — those valuable people who complete so much of the routine procedure. On the other hand the application of this tool may very well be the way in which a young internist or a physiologist acquires reputation for professional excellence. It will clearly be a tool that the older men find difficult to use so that a capable, aggressive younger man in any specialty where these things are used at all can perhaps turn them to his personal advantage very well. He will be able to do so, however, only by putting this skill on top of an already established skill. He will, therefore, never become a specialist in the use of radio isotopes. He will be a specialist who can use radioisotopes. *F. K. H.*

*Hamilton, J. G. and Soley, M. H., Studies in Iodine Metabolism by the Use of a Radioactive Isotope of Iodine. Am. J. Physiol. 127:557-1939.

## OUR ROLE IN WAR

Doctors have never played a tactical part in war. Even in the recent conflict, in which casualties were heavy, the medical profession did vastly more to lighten the load of human suffering than to strengthen the nation's fighting arm. As one studies the outlook of the future, it may well be shown that doctors will carry on one of the most vital parts in the defense of the nation under circumstances that will be extraordinarily different from the past. Yet they tend to be so absorbed in the scientific interests of their profession that few give serious thought to the nature of the military crisis that threatens, and still fewer take the time to consider the need of plans for meeting the immense burden that may suddenly be thrown upon them. *Excerpt: Medical Aspects of Civilian Defense, Charles H. Bradford, M.D., Boston, The New England J. of M., Aug. 3, 1950.*

# CORRESPONDENCE




## ANNOUNCE COURSE FOR INDUSTRIAL MEDICINE

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of Industrial Medicine. Candidates who complete satisfactorily the course of study will be awarded the degree Doctor of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily two years of residency (including internship) in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. The course of instruction consist of a two-year period of intense preliminary training in the basic phases of Industrial Medicine followed by one year of practical experience under adequate supervision in industry. During the first two years, the stipends for the Fellowships vary from $2,100 to $3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

## YOUR MENTAL HOSPITALS — EDUCATIONAL LEAVES FOR MEDICAL PERSONNEL

Realizing the importance of qualified and well-trained personnel and the shortages of professionally trained persons, the Illinois Department of Public Welfare has launched a program of educational leaves. Doctors entering the State Medical Service will be encouraged and stimulated to continue their education and training, and will be permitted to take specialized courses at training centers in Illinois and in the Medical Universities throughout the country.

Under this program, which will become effective in January, 1951, doctors who have served satisfactorily for three or more years may be authorized to take a six months period of training in an approved center. The physician or psychiatrist will receive his full salary and maintenance privileges during his leave. Training will not be restricted to psychiatry, but will include all phases of medicine and surgery, including tuberculosis, public health and specialized reasearch work.

This is part of a long time planning program. The State Hospitals will continue to make progress as long as their staffs continue to be stimulated by progressive physicians who, by training courses and seminars at the institutions, supple-

mented by periods of concentrated training at Specialty Centers, are advancing in knowledge in their respective fields of medicine.

Persons granted educational leaves benefit as individuals by securing professional training. There are multiple benefits over and above those gained by the individual. The patients gain by the improved quality of medical care and treatment. The physician, refreshed and stimulated by his period of training, transmits his enthusiasm to his fellow workers. The entire medical profession benefits from the improvement in the quality of its members.

As part of a staff development program, these periods of training will be beneficial in developing a high caliber of physicians and psychiatrists who may be promoted into higher positions and supervisory assignments. It is a part of the medical career service program of the Illinois State Mental Hospitals.

Educational leaves will gradually be expanded to include other professional groups, namely, the nurses, the occupational and recreational therapists, the social workers and the psychologists.

G. A. Wiltrakis, M.D.
Deputy Director

## ORGANIZATION IN WOMAN'S AUXILIARY

Organization as Webster states it: to establish and systematize; to so arrange as to be ready for service. This is my duty this year as your President Elect of the Woman's Auxiliary to the Illinois State Medical Society. According to the By-Laws, the councilors are members of the organization committee. However, I believe each individual member should feel a part of the organization committee. This work must be continuous. As our National Chairman states: "The foundations of the Auxiliary — our traditions — ideals — objectives — are ours for the asking. We must continue building to benefit perpetually from the work that has been achieved."

Since our Convention in Springfield last May four counties have organized. This was accomplished through the marvelous cooperation of the Doctors.

There are many Counties in our State that do not have any representation in our Auxiliary. I hope before my year ends that much of this can be rectified. As least we should have members at large. The time has come when the Auxiliary has so proved its worth that the question is not are you an auxiliary member? but why are you not a member? I hope I am not assuming too much when I ask the Doctors who are officers in the Counties unorganized — when they read this — to help us establish an Auxiliary in that County. We must have the consent of the Medical Group before we can do any organizing. This is our first step.

I feel that now is the hour the profession needs us. We have an opportunity to aid them and ourselves too, in a real fight for freedom. We do not want to be found wanting. Our second step is to present and explain purposes and ideals of the Auxiliary. Our third step to call an organization committee, elect officers if possible. Our fourth step to be properly informed. Let us be an asset — Let us speak with authority — Let us know when to keep quiet — when to speak to advisors.

Let us be responsible for new members. Let us try to have every Doctor's wife an Auxiliary member. Let us have a happy and fruitful year.

(Mrs. J. M.) M. G. McDonnough
President-Elect

## ARMY SHORT 1,325 PHYSICIANS NOW!

The Army currently has an immediate shortage of 1,325 physicians. These physicians must be provided very shortly if essential medical service is to be maintained. The following steps have been taken toward this objective: A limited number of World War II physicians are being called involuntarily from the Reserves. In addition to those called as individuals, Reserve medical officers assigned to Organized Reserve Corps units be called to duty as their units are brought into active service. The professional complements of the larger medical units will not be called for initial training phases. Approximately 500 physicians with World War II service are affected by individual and unit recalls.

In addition, the Navy is making an initial recall of 570 V-12 physicians in the Naval Reserve who have not had previous active duty. These physicians will be detailed to the Army to meet current critical requirements. As soon as the Selective Service System starts meeting

our requirements, Navy personnel will be returned to that service and involuntarily recalled Reserve officers will be released from duty except for those in the higher grades being utilized as specialists and in senior command assignments. Specialists cannot be released unless Public Law 779 provides replacements for them. Army requirements will be 3,200 physicians to meet current expansion plans.

From the foregoing, it is obvious that practically all physicians in category one under Public Law 799 as well as a sizable proportion of category two will be brought on active duty. There are certain specific advantages that will accrue to those who volunteer now rather than wait a few weeks for the draft. First, volunteers will receive an additional $100 per month professional pay. Second, those who volunteer and are commissioned need not register. Third, professional skills can be utilized better than under Selective Service, which makes only bulk numbers of physicians available without classification. Fourth, those who volunteer will have the satisfaction of knowing they are rendering service to their country at a time when international tensions are threatening a way of life which has made possible the development of a medical profession that embodies the highest principles and ideals of the Hippocratic oath.

Individuals can obtain information and necessary instructions for obtaining Reserve Commissions from the Office of the Unit Instructor, in the Military District in which they reside. Inquiries also may be directed to the Surgeon of the Army Area in which they reside, or the Surgeon General, Department of the Army, Washington 25, D. C.

## AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY

The ninth annual meeting of the American Academy of Dermatology and Syphilology will be held in Chicago from Saturday, December 2nd through Thursday, December 7th, it is announced by Dr. John E. Rauschkolb, secretary-treasurer of the Academy, of Cleveland (P. O. Box 6565), Ohio.

The principal sessions will be held at the Palmer House, with special courses in histopathology and mycology scheduled for Saturday and Sunday, December 2 and 3, at the Medical Schools of the University of Illinois and Northwestern University. Special courses in x-ray and radium therapy, and bacteriology of the skin, will be held Saturday and Sunday at the Palmer House. There will also be special courses in anatomy and embryology of the skin and special problems in dermatohistopathology Sunday at the Palmer House.

Extensive scientific and technical exhibits will be set up in connection with the meeting.

Special lectures will be given on: Pemphigus Vulgaris, "Dermatologic Aspects of Eruptive Fevers in Children", "Use of Cortisone and ACTH in various clinical states with special regard to dermatologic aspects", "Dermatological Manifestations of Parasitic Infections", "The Histological diagnosis of Malignant Melanoma", "Cyclic Estrogenic Hormone Therapy of Acne Vulgaris in the Female", "Value of Plasma L. E. Test in Diagnosis and Treatment of Lupus Erythematosus: and Influence of Cortisone and ACTH".

## DERMATOLOGICAL PRIZE ESSAY CONTEST

The American Dermatological Association is offering a prize of three hundred dollars for the best essay submitted of original work, not previously published relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate younger investigators to original work in these fields.

Manuscripts typed in English with double spacing as for publication, together with illustrations, charts and tables, are to be submitted in triplicate not later than February 1, 1951, and should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102-110 Second Avenue, Southwest, Rochester, Minnesota.

Competition in this prize contest is open to scientists generally; not necessarily physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. This contest is planned as an annual one, but if in any year, at the discretion of the Research Aid Committee and judges,

no paper worthy of a prize is offered, the award may be omitted.

The prize winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the three hundred dollars prize. Further information regarding this essay contest may be obtained by writing to the secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be the Diamond Jubilee Observance of its founding and will be held May 23-26, 1951, at the Homestead, Hot Springs, Virginia.

## CLINICS FOR CRIPPLED CHILDREN LISTED FOR DECEMBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the December schedule of clinics for physically handicapped children. The Division will conduct 11 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physicians, who are certified Board members, are selected the clinicians. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services:

The December clinics are:

December 5—Fairfield, Masonic Temple
December 6—Aurora, Copley Hospital
December 6—Rock Island (Cerebral Palsy), St. Anthony's Hospital
December 7—Macomb, Marietta Phelps Hospital
December 8—Chicago Heights (Rheumatic Fever), St. James Hospital
December 12—Peoria, St. Francis Hospital
December 12—E. St. Louis, Christian Welfare Hospital
December 13—Springfield (Cerebral Palsy), Memorial Hospital
December 13—Hinsdale, Hinsdale Sanitarium
December 14—Springfield, St. John's Hospital
December 14—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
December 15—Chicago Heights (Rheumatic Fever), St. James Hospital
December 19—Peoria, St. Francis Hospital
December 19—Effingham (Rheumatic Fever), Douglas Township Bldg.
December 20—Chicago Heights, St. James Hospital
December 21—Normal, Brokaw Hospital
December 21—Rockford, St. Anthony's Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

## OTOLARYNGOLOGY POST GRADUATE CONFERENCE

The Annual Postgraduate Conference in Otolaryngology at the State University of Iowa, will be conducted on November 27 to December 2, 1950, at the University Hospitals, Iowa City, Iowa. Further information may be obtained from the Director of Medical Postgraduate Studies, Medical Laboratory Building, Iowa City, Iowa.

Dean M. Lierle, M.D.
Iowa City, Iowa

# ORIGINAL ARTICLES



# Clinical Significance of the Femoral Hernia

**Manuel E. Lichtenstein, M.D. and Keith H. Frankhauser, M.D.**
**Chicago**

Femoral herniae are not uncommon but their importance lies in the errors commonly made in the diagnosis of this condition and the failure to appreciate fully the clinical significance of the condition when present.

In a period of four years (1946-1949) there were admitted to the Norwegian-American Hospital, Chicago, 50 patients with femoral herniae. This report concerns the findings in this group and is presented with the hope that the observations recorded here will be of interest to those called upon to treat this condition.

Table 1 shows that 13 of the 50 occurred in men — a ratio of approximately 1 to 3 in the female. The largest number were fund in individuals over forty years of age. Only 8 of the 50 were under forty while 17 were over sixty years of age. This is significant, because elderly patients frequently develop a variety of abdominal complaints which may be attributed to an intra-abdominal lesion while a significant femoral hernia is overlooked in spite of incarceration or strangulation. There were 37 on the right side, 10 on the left side and in three instances the condition was bilateral. It is likely that the sigmoid colon overlying the femoral space, plays a role in preventing the more fre-

TABLE 1 AGE, SEX, LOCATION

| Age | No. | Male | Female | Right | Left | Bilat. | Sugr. | Med. |
|---|---|---|---|---|---|---|---|---|
| 5-19 | 3 | 1 | 2 | 2 | 1 | 0 | 3 | |
| 20-29 | 3 | 0 | 3 | 3 | 0 | 0 | 3 | |
| 30-39 | 2 | 1 | 1 | 2 | 0 | 0 | 1 | 1 |
| 40-49 | 11 | 2 | 9 | 9 | 2 | 0 | 11 | |
| 50-59 | 14 | 3 | 11 | 11 | 2 | 1 | 14 | |
| 60-69 | 12 | 5 | 7 | 7 | 4 | 1 | 11 | 1 |
| 70-79 | 5 | 1 | 4 | 3 | 1 | 1 | 4 | 1 |
| Total | 50 | 13 | 37 | 37 | 10 | 3 | 47 | 3 |

From the Division of Surgery Northwestern University Medical School, Cook County Graduate School of Medicine and the Norwegian-American Hospital, Chicago, Ill.

TABLE 2 RELATIONSHIP BETWEEN INGUINAL AND FEMORAL HERNIAE

| Case | Age | Sex | Previous Operation | History |
|---|---|---|---|---|
| 1. | 22 | F. | 1 yr. | Inguinal hernia repair done on right side. No definite sac found. Hernial mass still present following surgery. Patient refrained from heavy lifting until she noted pain and gradual enlargement of mass. Repair of femoral hernia cured the condition. |
| 2. a. | 50 | F. | 9 yrs. | Immediately following an inguinal operation for repair of a hernia the patient noted persistence of the original hernia. Recent development of pain and gradual enlargement prompted desire for treatment. Repair of the femoral hernia cured the condition. |
| 3. | 39 | M. | 9 mo. | Following an inguinal operation for hernia the patient noted the same lump present in the groin. Repair of the femoral hernia cured the condition. |
| 4. b. | 54 | M. | 20 yrs. | The patient noted the development of a mass in the groin many years after repair of an inguinal hernia. The second hernia was not in the same location as the first. There appeared to be no relationship between the two conditions. |
| 5. | 60 | M. | 14 yrs. | The present mass in the femoral region was not the same as the mass removed by an inguinal hernia repair 14 years previously. |
| 6. c. | 54 | M. | 0 | Rupture in groin 15 years duration. Increase in size during last six years because of severe cough. Clinical diagnosis: Right inguinal hernia. At operation there were found a pantaloon hernia in the inguinal region and a right femoral hernia. |
| 7. | 69 | M. | 0 | The patient was admitted to the hospital 3 months previously because of acute urinary retention due to benign prostatic hypertrophy. Prostatic resection was done. Returned for repair of bilateral groin hernia which had enlarged tremendously before prostatic resection was done. At operation he had bilateral femoral and a left indirect inguinal hernia. |

a. Inguinal operation failed to cure femoral hernia.

b. Inguinal operation unrelated to femoral hernia.

c. Inguinal operation for inguinal hernia concomitant with femoral hernia.

quent development of the hernia on the left side.

Table 2 is especially significant. It concerns the relationship between inguinal and femoral herniae. More commonly the femoral hernia is mistaken for an inguinal hernia and the effort at repair is misdirected. Even in this small series it was found in three instances. (Table 2-a). The importance of the physical examination in distinguishing between the two must be emphasized. Examination of the patient in the standing position makes the distinction obvious on inspection in the majorty of instances. On palpation the mass of the femoral hernia is lateral to the pubic spine (Figure 1).

The sac of the femoral hernia is made up of three layers (Figures 1 a-b). The outer layer of fascia is derived from the femoral sheath. This layer frequently is so thin that it forms a transparent surface envelope. The inner layer is an outpouching of the peritoneum into the femoral canal. The intermediate layer is derived from the extraperitoneal fatty layer. This fatty and vascular layer varies considerably in thickness. Thus the wall of the sac may be thick (Figure 1-c), or thin (Figure 1-d) according to the fatty investment in the intermediate layer. Once the sac has developed in its herniated position, replacement into the abdomen is the exception and not the rule. The contents of the sac (bowel, omentum or pelvic viscera) may be replaceable, but the sac itself usually remains more or less fixed in its newly developed position in the subcutaneous fat of the groin. This is one of the characteristic features of the femoral hernia and helps to distinguish it from the inguinal hernia. The sac of the indirect inguinal hernia is a pouch of peritoneum occupying a position within the cord structures surrounded by the vascular layer and the internal spermatic fascia. When the contents of the hernial sac are reduced it may be impossible to palpate the sac because of its thin wall and its seclusion within the cord structures. The sac of the direct inguinal hernia is made up of three layers. The outer thin-walled fascial layer is derived from the defective transversalis fascia in the triangle of Hesselbach. The inner layer is con-

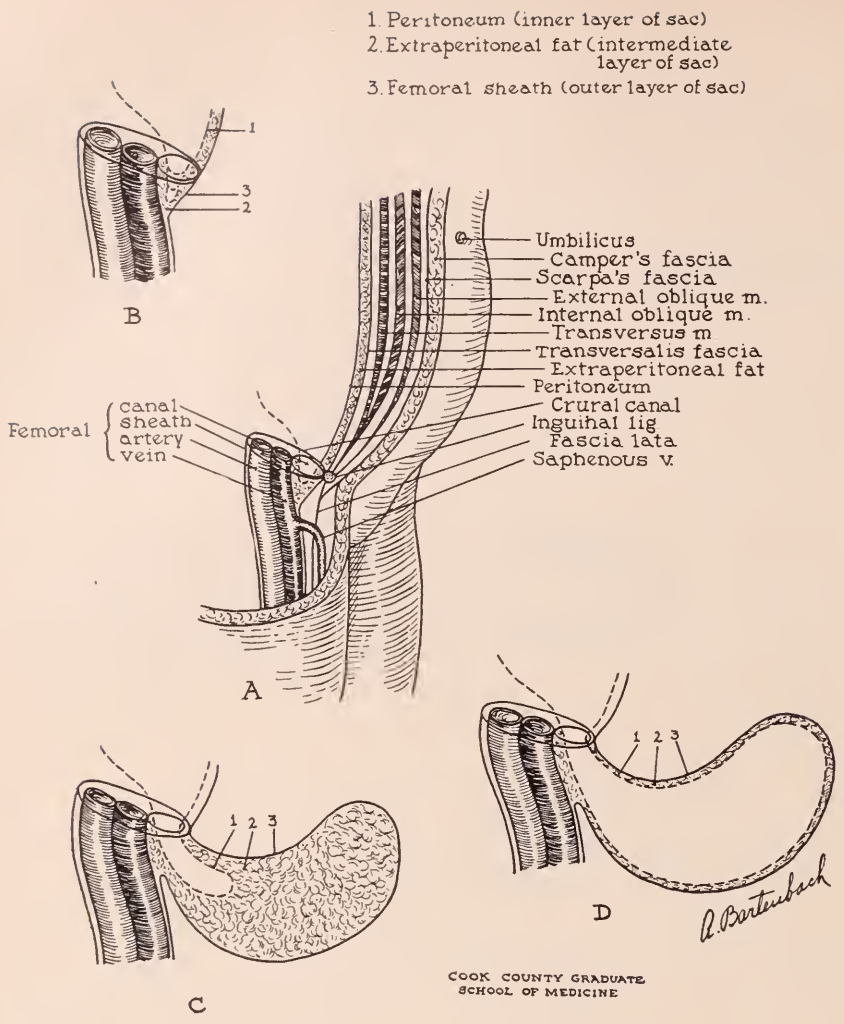



**Figure 1. Anatomy of the femoral hernia. Note the three layers which constitute the sac and the variation in thickness of the intermediate layer.**

tinuous with the peritoneum. The intermediate layer consists of extra-peritoneal fat. This sac commonly has a broad base, and with the patient in a reclining position both the sac and its contents may be returned into the abdomen with comparative ease.

The repair of an inguinal hernia will not prevent the development of a femoral hernia (Table 2-b). In the two instances recorded here 14 and 20 years elapsed between repair of the inguinal and femoral herniae. It is doubtful that the repair of an inguinal hernia anatomically disturbs the femoral region sufficiently to predispose to femoral hernia formation. The lapse of many years would indicate that other factors play a role in the development of the hernia.

The other factors are illustrated in (Table 2-c). In this group both inguinal and femoral herniae were present. The increased intra-abdominal pressure, occasioned by coughing in one instance and straining in the other, played a role in the increase in size of the hernial protrusions. The higher incidence of herniae in the elderly adult is very likely associated with the increase in intra-abdominal pressure due to coughing, straining (constipation, difficulty in urination and laborious physical effort) and obesity acting on tissues that have undergone wear and tear over many years. Also the actual growth of fat in the intermediate layer of the sac helps to increase the size of the protruding mass.

Table 3 is a summary of three patients who were not operated upon. One of these, (Case 1) left the hospital without operation following reduction of an incarcerated hernia. Since a hernia presents the risk of a serious complication such as bowel obstruction or strangulation, it is advisable that femoral herniae be repaired soon after their presence is detected. The hernial sac is superficial. The operation may be done under local anesthesia if preferred with little disturbance to the patient. Early ambula-

TABLE 3 SUMMARY OF PATIENTS GIVEN NON-SURGICAL THERAPY.

| Case | Sex | Age | Diagnosis on admission | Disposition | Length of hosp. stay. | Duration of obstruction from history. |
|---|---|---|---|---|---|---|
| 1. | F. | 32 | Femoral hernia with pain in RLQ | Recovery & Discharge | 2 days | |
| 2. | F. | 78 | Acute intestinal Obstruction — Cause undetermined | Death (a) | 20 hrs. after admission | 6 days |
| 3. | F. | 69 | Cerebrovascular accident and bronchopneumonia | Death (b) | 19 days after admission | 5 days |

a. — Post mortem examination showed strangulated bowel in a femoral hernia sac.

b. — Post mortem examination showed strangulated bowel in a femoral hernia sac.

tion is desirable and the disability usually is the least of any associated with abdominal hernia repair. Recurrence of a femoral hernia when properly repaired is exceedingly rare. (Figure 2).

One patient (Case 2) died from acute intestinal obstruction of six days duration but less than one day after admission to the hospital. The patient was treated medically and the hernia remained unrecognized. At autopsy the strangulated femoral hernia was demonstrated. Another patient (Case 3) died from a combination of causes including bowel obstruction. This patient was an obese 69 year old white female with a past history of two cerebrovascular accidents. On admission the patient was in a semiconscious state and although she did not respond to questions she co-operated when requested. Additional findings disclosed were left sided bronchopneumonia, auricular fibrillation and an old right hemiplegia with a recent left hemiplegia. The patient showed some improvment for the first 10 days following hospitalization. On a liquid diet there was no nausea or vomiting.

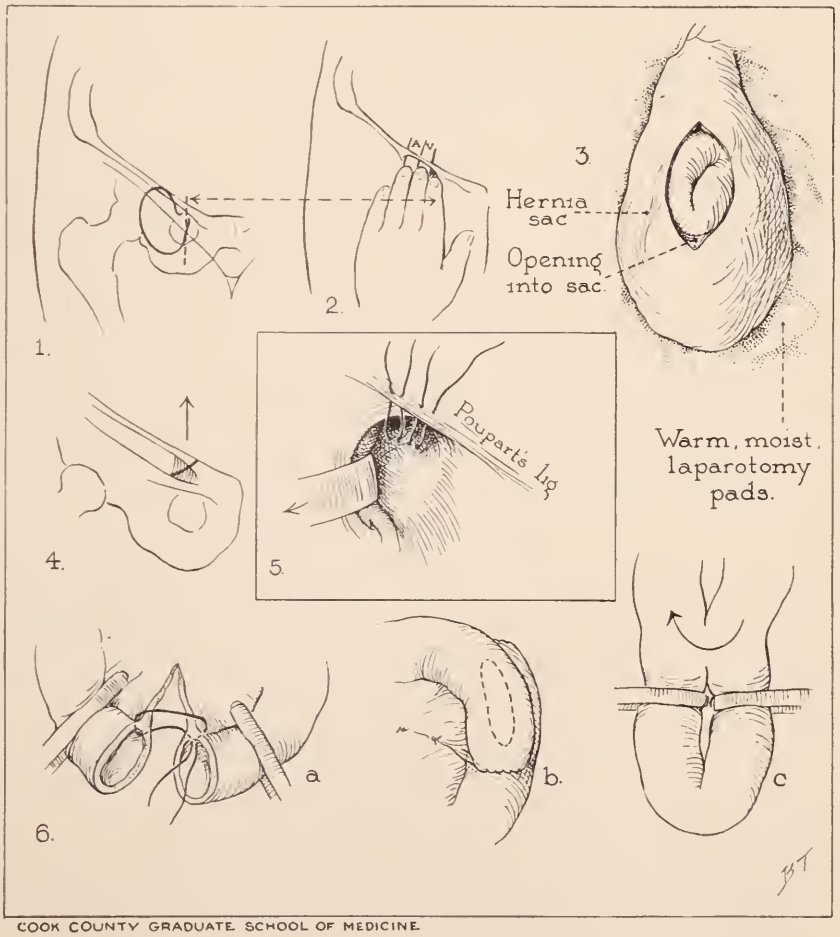



**Figure 2. 1. Site of neck of femoral sac. 2. Location of neck determined by index finger placed medial to the femoral vein with the ring finger on the pulsating femoral artery. 3. Incision into femoral ring. 5. Closure of the ring. 6. Methods for restoring continuity following bowel resec- sac. 4. Method for enlarging the tion.**

Although urinary and fecal incontinence were noted on admission to the hospital, there had been no bowel movements for five days prior to death. Post mortem examination showed strangulated bowel in a femoral hernial sac.

It is not likely that any benefit would have been derived from the repair of the femoral hernia in this case. However, it indicates that the diagnosis was incomplete and suggests that repeated examinations, including the femoral region be made in any patient with bowel obstruction or in one whose bowel movements have ceased for any length of time. The two deaths noted here in elderly patients, associated with undiagnosed strangulated femoral herniae, illustrate the significance of the earlier comment. It is necessary to keep in mind this likely cause for sudden constipation or bowel obstruction in the elderly patient who cannot or does not indicate the site of the incarcerated bowel.

That such deaths may occur without a full appreciation of the significance of the femoral hernia is attested to, also, by the reports of Dunphy[1], Gatch[2] and others[5 7].

TABLE 4 OPERATED FEMORAL HERNIAE

(47 Patients had 50 herniae)

| Type of Femoral Hernia | No. | Mortality | Comment |
|---|---|---|---|
| 1. Uncomplicated | 33 | 0 | a, b |
| 2. Incarcerated or strangulated without resection. | 12 | 0 | c |
| 3. Strangulated bowel with resection. | 5 | 0 | See Table V |
| TOTAL | 50 | 0 | |

a. In one hernial sac there was found a nodule showing metastatic papillary adenocarcinoma. In addition a lymph node showed chronic lymphatic leukemia.

b. In addition to the herial sac the specimen showed an enlarged lymph node which on microscopic examination disclosed lymphosarcoma.

c. In addition to the hernial sac the specimen showed reticulum cell type lymphosarcoma.

Table 4 presents the signficant data concerning the 50 femoral herniae operated upon. In 33 uncomplicated femoral herniae uneventful recovery took place following surgery. In two of them additional diagnoses were made following examination of the specimens removed at operation. In one a tiny nodule was found. Microscopic examination disclosed this to be metastatic carcinoma for the ovary. The hernia which had been non-symptomatic for several years, had only recently become enlarged and painful. The sac contained easily replaced contents which were reduced before surgery was done. Tissue removed also contained a lymph node typical of chronic lymphatic leukemia, but the latter was known before surgery was done. In the second instance a lymph node was removed with a hernial sac containing fluid.[6] The microscopic picture showed lymphosarcoma from which condition the patient subsequently died. In twelve instances of incarcerated or strangulated femoral herniae surgery relieved the condition. In one of these, sections from a removed lymph node also showed lymphosarcoma.

Thus in the 50 femoral herniae, three instances of malignancy were found. This is significant in the prognosis when one is called upon to repair what looks like a benign condition and is confronted with a disease of grave significance. This can hardly be called "uneventful recovery."

Table 5 is a summary of the five patients with strangulated bowel all of whom required bowel resections and all of whom recovered. However, an analysis of these cases illustrated several points of clinical signifiance. Even in this small series delay in necessary treatment occurred in three instances where the full signficance of a femoral mass was not appreciated by the house staff on admission of the patient to the hospital. While bowel resection was readily accomplished in each instance some disability may have been averted by earlier surgery, especially in case 2. Recovery and healing eventually occurred even in this case. However, early diagnosis and early treatment will leave less to chance and avoid the hazards which delay entails.

Delay in treatment is often due to error in diagnosis. This is frequently the result of failure to examine for a mass in the femoral region in the presence of pre-obstructive gastro- intestinal symptoms, or failure to appreciate the significance of a femoral mass when it is noted.

One of the most common causes of intestinal obstruction is incarceration of abdominal contents in a herial sac. Examination, therefore, of the sites of the hernial rings is necessary to make a diagnosis. Local pain may be so mild that it does not direct attention to the seat of the trouble. The mass is commonly small in

TABLE 5 SUMMARY OF 5 PATIENTS WHO HAD BOWEL RESECTIONS.

| Case | Age | Sex | Duration | Date & Time of admission | Date & time of Surgery | Complications | Date of Discharge |
|---|---|---|---|---|---|---|---|
| 1. | 65 | F. | 48 hrs. prior to admission abdominal pain, cramps & vomiting | 5-8-46<br>5:30 p.m. | 5-8-46<br>9:30 p.m. | None | 5-28-46 |
| 2. | 59 | F. | 48 hrs. prior to admission abdominal pain cramps and vomiting | 7-18-47<br>5:00 p.m. | 7-22-47<br>3:00 p.m. | Temp. over 101 for 6 consec. days pelvic abscess fecal fistula wound infec. | 9-1-47<br>wound healed |
| 3. | 50 | F. | 6-8 hrs. prior to admission abdominal pain and cramps | 10-11-47<br>2:45 p.m. | 10-12-47<br>4:30 p.m. | None | 10-22-47 |
| 4. | 44 | F. | 24 hrs. prior to admission abdominal pain and cramps | 11-14-49<br>7:00 p.m. | 11-15-49<br>6:30 p.m. | Temp. over 101 for 48 hours | 11-26-49 |
| 5. | 54 | F. | 8-12 hrs. prior to admission abdominal pain cramps and vomiting | 12-31-49<br>1:15 a.m. | 12-31-49<br>3:00 a.m. | None | 1-10-50 |

size and for this reason, in some instances, the patient or the surgeon may fail to appreciate the relation between the abdominal symptoms and the unobtrusive mass present in the groin.

## SUMMARY

In this series, there were 50 patients with a total of fifty-three femoral herniae. Forty-seven of these patients were operated on for 50 herniae (three bilateral). There were no deaths in the group that had surgical treatment. Five of these patients required resection of strangulated bowel.

The following clinical features of this condition are emphasized.

1. Femoral herniae are frequently mistaken for the inguinal variety and remain uncured following the inguinal operation.

2. Femoral herniae frequently are overlooked as a cause for bowel obstruction. This error in diagnosis is responsible for delay in specific treatment for this condition.

3. Bowel resection when undertaken early, following strangulation is easily accomplished with little disability for the patient.

4. Neglect of the condition favors complications which add to the disability and at times results in the death of the patient.

5. The possibility of malignancy associated with femoral hernia must be appreciated.

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# Limitations of Cytological Diagnosis From the Pathological Standpoint

**N. Chandler Foot, M.D.**
**New York, N.Y.**

I have no formal paper to present to you today. I am going to talk "on the hoof", so to speak, and bring up various pitfalls that one encounters in connection with practicing exfoliative cytology.

One of the first difficulties in the method is the obtaining of the smears. The smears necessarily are usually obtained by the practitioner and are then sent in to the laboratory for diagnosis and it is very important that those smears be made in the proper way.

In connection with vaginal smears, it is important that no examination be made on the vagina immediately prior to taking the smear. The vagina should be in a relatively resting condition, otherwise a great many cells are exfoliated on account of the manipulation that goes on and the tremendous number of normal elements obscures the abnormal elements, so that one can't make a ready diagnosis. Otherwise the taking of vaginal smears is fairly simple. However, it is important that sufficient material be obtained and that the smears be reasonably copious and homogeneous before they are fixed. We often get smears that are little spirals of insufficient material and one can't do anything with them at all.

In the case of taking smears of suspected carcinoma of the lung; in the first place, if you are going to take a smear of sputum it is necessary that the physician be asked to get a "deep cough" specimen. Shallow cough specimens merely produce cells from the upper respiratory tract and its very upper extremity, usually the oral cavity, and show little. Later I'll show you a slide from one of those.

In taking washings, tracheal or bronchial washings, it is important that the material be obtained through the mouth rather than through the nose because the introduction of the nasal tube is apt to dislodge nasal mucosa which, as you know, is quite complicated and this introduces a lot of factors that make diagnosis difficult.

In making smears it is very important that they should be immediately fixed in alcohol and ether in equal amounts and not allowed to dry before they are fixed. I am going to take that matter up in a minute.

In taking smears from fluids, such as washings, a centrifugate is obtained and then mixed with equal parts of alcohol and the mixture sent into the laboratory. It is better that the smears be made by the technician and not the practicing physician in these cases.

In the case of taking urinary sediments, the procedure is about the same; but if the physician suspects that he is dealing with a prostatic carcinoma, it is well that he should take more than one specimen. It is best to obtain at least three specimens and possibly four. One of those, the first, is a partially voided specimen. I mean by that that the bladder is partially emptied. It is a specimen of the first urine voided from the bladder. Then the prostate is massaged and the prostatic secretion collected and a smear made directly from this. Thirdly, the bladder is completely emptied, and that is specimen number three. Fourthly, an ejaculate is advisable if it can be obtained. In that way everything has been done to obtain cells from the prostate.

In the case of gastric specimens the use of the Rehfuss tube with a bucket tip has been found to be the best, and in that way we can sometime get cells from carcinoma of the gall bladder and pancreas as well as from the stomach. The smears are made in essentially the same way. In that case one washes out with a con-

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**Presented before the Section on Pathology, 109th Annual Meeting of the Illinois State Medical Society, Chicago, May 17, 1949.**

siderable amount of fluid. The patient is asked to drink from two to three hundred c.c. either of salt solution or Ringer's solution along the tube and then that is pumped out and sometimes repumped into the stomach and reaspirated and the patient shaken. It is thus very important that this material be taken in the proper fashion. It is also important that the practitioner send in some sort of a history. You'd be surprised to see how many specimens we get which are accompanied merely by a diagnosis and the name of the patient. The age isn't given; the length of the symptoms isn't indicated; and one is left completely in the dark as to how to proceed.

Now, so far as the smears are concerned, I mentioned drying . If a smear is allowed to dry before it is fixed, the cells shrink. Part of them adhere to the slide and part of them shrink back so that there is a production of pseudopodia and irregularity of shape, and very often vacuoles which are all artefacts and very largely nullify the effect in reading the specimen.

After fixing the slide in alcohol and ether I have personaly found that it can be allowed to dry and then can be replaced in alcohol and ether for a short time before it is run through the stains. The method of putting on glycerin that I mentioned yesterday is apparently not entirely satisfactory. It was an idea of Ayre's and I have been told that it is difficult to get rid of the glycerin and get good stains after the sections come in. That is something I learned this morning from a man who has tried it and is thoroughly dissatisfied with it. The type of fixation, alcohol and ether, is really very important because we experimented with other types of fixation, ordinary formalin and Zenker's solution and so on, and found that they didn't work as well as this very simple ether and alcohol which gives you a very transparent smear.

Of course, if you want to use Giemsa's solution, it is permissible to alter the fixation slightly and use a solution of saturated mercuric chloride in absolute alcohol and then Giemsa's stain. Usually the stains are largely a matter of personal choice. Papanicolaou has a great many of them and Shorr has invented a very good polychromatic stain; even hematoxylin and eosin give a very good idea on these smears, but a poor stain is a poor stain and if your technic isn't carried out scrupulously, interpretation of the resulting smears is difficult.

I have mentioned the difficulty of trying to deal with insufficient material in smears. That comes up repeatedly: smears which have so little material on them that one can't make anything out of them at all.

It is also important in taking gastric smears that the patient be in a fasting condition and that there is nothing in the stomach. The extraneous material introduces all sorts of cells which the pathologist is more or less familiar with, but which are quite foreign to the human body. That is, bits of foodstuff, starch granules, muscle in the form of meat, and other such material which is readily misinterpreted.

In connection with the washings from the colon which are surprisingly illuminating when they are properly done, it is important that the patient should be thoroughly cleaned out with a purge, a drastic purge like castor oil or something of that sort and then kept on a fluid diet for two days before the high colonic enema is given which produces the cells. Otherwise there will be a great deal of fecal material which will be extraneous and will have to be ruled out.

Now we come to the matter of the cytologist himself. With the introduction of the method there has been an erroneous impression that the technician in the laboratory could be trained to read these smears. That is true only when the technician has been trained for a long time. Technicians, some of them, get to be very excellent cytologists, particularly those with a background of biology from college and so on, but one must remember that the technicians are not qualified physicians and this diagnosis is after all the practice of medicine and there is a great deal of responsibility inherent to it, so that the idea of training a technician to do the smear work in an office or a group is very erroneous.

I was told last spring by a prominent pathologist that he knew of one of his technicians who had gone off to learn this smear method in a doctor's office by the simple procedure of trial and error. She was quite starry-eyed. She thought she was going to be of great use to humanity and that she was going to make the diagnoses for the doctor. Fortunately she was a very honest girl and after a week or so at the

job she realized that she was not qualified to do it and that she couldn't do it.

The average pathologist is entirely capable of learning the method. When I say learning, it is a matter of accustoming oneself to the appearance of smears as opposed to that of sections.

We are all used to looking at sections and when we get to smears they are a little bit different, but after all they are not different from smears of blood or other such material with which the clinical pathologist is dealing all the time.

However, I also think, if a man is going to take up exfoliative cytology, that as part of his work he should familiarize himself with the pitfalls that arise in connection with this diagnosis. A perfectly blatant and obvious carcinoma can be diagnosed by almost anyone in pathology.

But there are some of these smears that we've learned empirically to interpret as possible carcinoma which have to be learned by experience. So it is just as well to have a little of this.

It has been told me that the osteopaths here in Chicago are instituting laboratories for cytologic diagnosis and that the diagnoses are being handed out wholesale and are not what one might call entirely reliable.

Now we come to the economic drawbacks of the method which are considerable. The idea that the average pathologist in a hospital or clinic can put this work on top of his daily stint and get away with it is erroneous. It is only when there are very few smears coming in that the pathologist has time to do this and, possibly unfortunately, there has been quite a lot of publicity about the method which has caused the public to demand smear diagnosis. As a result a pathologist is found to be entirely incapable of carrying on all this added load of work.

He can get around it to a certain degree by training technicians; that is the technicians screen out the suggestive material and pass it along to him for his okay and the negative material he just doesn't look at. It has been estimated that fifteen minutes per slide is about the average time required to diagnose with accuracy and you can see if you have eight or ten smears and multiply that by fifteen minutes, it is going to take up a lot of your day. So that that introduces the necessity for setting up a separate laboratory for this work.

In most instances doing so entails a certain amount of financial expenditure and a budget is necessary to swing this added work. Usually one of the members of the Department of Pathology, or if there be no Department of Pathology, a new man has to be engaged to act as cytologist and he should have one or two technicians who are capable of screening and making the smears and very often it is necessary to have an added secretary to get out the reports.

The reason for this is that the minute one announces that this service is available in the hospital the physicians begin to include it in the so-called "daily workup" of the patient. You are all familiar with "the workup." You get a flat plate of the chest and you get a blood chemistry, and you get a urine chemistry, and then you get a blood count and you go on to an E.K.G. — possibly and E.E.G. — and then you send in one of these smears to the laboratory on the chance of picking something up and then you get out your stethoscope and do a little investigation. [Laughter]

As an illustration of this, here is a list of specimens which were sent in to our laboratory last winter. On December 9th I picked up four of them in order as they came in. First was a sputum and the diagnosis was "uninary retention." The second was a gastric smear and the diagnosis was "combined system disease." The third one was a good deed in a naughty world; it was a gastric smear and the diagnosis was "suspected gastric carcinoma." The fourth one was a sputum and the diagnosis was cholecystitis. Those were taken from a list of specimens sent into Dr. Papanicolaou's laboratory.

Here are some other startling requests we had. Urinary specimen with a diagnosis of ca. of the pancreas. Sputum, menopausal syndrome. A urine specimen and the diagnosis, "observation." That was obviously a workup. We had a gastric smear and the diagnosis cholecystectomy. They had just done a cholecystectomy so they did a gastric smear. A sputum, "cholecystectomy." A sputum, diagnosis, carcinoma of the rectum. A rectal washing, diagnosis "Esophageal diverticulum, and they specified it was of the pulsion type and finally a sputum and diagnosis "leak" in the rectum, spelled l-e-a-k. That shows you

what you have to deal with if you set up one of these services. They were taken from Dr. Papanicolaou's department in the New York hospital. The specimens were all sent down by energetic and ambitious young residents, probably, and some of these diagnoses may have been slightly garbled by the nurses in transmission, but they were essentially correct and naturally the results were completely negative. So we have those things to deal with from the economic standpoint.

Then even qualified men make misinterpretations. There are certain cells with which one has to become familiar and which must be ruled out and very often two or three men examining the same case may give two or three different interpretations. One example occured this winter. A woman, who was personally known to me went to one of the large hospitals in New York. She had premenopausal symptoms and a vaginal discharge — with spotting — and a vaginal smear was reported as carcinoma. Her husband asked me if I would look at the slide which I did and I found a premenopausal slide without any evidence of carcinoma and handed it on to Dr. Papanicolaou who confirmed it. Again a smear was taken and again the same positive report came in at the other hospital and again Dr. Papanicolaou and I countermanded it and the gynecologist did a curettage obtaining completely normal cells so far as carcinoma was concerned, completely normal endometrium. So that men in very large gynecological services sometimes slip up because of insufficient training.

That particular man had worked up the hard way. I think he is not a pathologist. He was a gynecologist and he had a certain amount of experience in reading these smears. Dr. Simonds just spoke of the diagnosis of one cell: that is pretty hazardous. Sometimes we find one very odd cell in a smear which we are reasonably sure is a carcinomatous cell, but it would be unjustifiable to make a diagnosis of carcinoma on the basis of that one cell. It is like the famous swallow in the summer time, one of them does not make a summer, and one abnormal cell doesn't necessarily make a diagnosis of carcinoma. We prefer to get clumps of cells before we issue our highest grade of classification.

Now, Papanicolaou has five classes of reports, which may seen too many to most of you. It did to me when I first joined his department, but I think the wisdom of it has come out. Class One is completely negative. The cells are quite normal. Class Two indicates abnormal cells but not neoplastically abnormal. They are abnormal cells which can be interpreted as a result of inflammation or irritation. Class Three begins to be questionable and the minute a "class three" diagnosis is issued from the laboratory it automatically indicates a request for another specimen. It is when we find single cells that we are very apt to call smears Class Three; when we only found one cell that we thought was carcinomatous. Class Four is presumably carcinomatous and that category could possibly be omitted. Class Five is conclusively carcinomatous and that diagnosis is issued when there are clusters, groups and ample evidence of carcinoma being present.

Now when we report Class Five it is always advisable to get a biopsy and check up on this with sections. When I say advisable, it is almost a necessity. But in some cases we do make a diagnosis on the basis of smears if we have strong clinical support. That is particularly true in the case of the urinary system and in the case of the lung. There, it is impossible to take biopsies in those two instances. For instance, you can't take a biopsy from the pelvis of the kidney without doing a laparotomy and you can't take a biopsy from one of the bronchi that cannot be reached by a brnochoscope.

Wherever it is possible to take a biopsy it should be taken and no operation should proceed unless that biospy has confirmed the report on the smear. If an operation is undertaken on the basis of evidence from smears, there should be two or three positive reports preceding that operation. In that way we are not liable to go wrong.

## DISCUSSION

Dr. Pilot: Dr. Foot's fine talk very much reflects what we brought up a year ago. I think it is quite obvious that in order to avoid all the pitfalls that he brings out young men who are training in this field must become thoroughly acquainted with the exfoliated cell of normal secretions and of secretions under inflammatory conditions. I

think most of our puzzling cases in the sputum and in the cervix smears are from benign ulcerated processes that give rise to peculiar changes in the epithelium that in the past we have referred to as epithelial cells giving the bizarre appearance due to inflammatory hyperplasia.

I have only one question in relation to this work. I wonder if Dr. Foot would briefly give us his experience on the relative merits of the staining procedures. We, of course, use the Papanicolaou staining in connection with our vaginal smears because of the clear and sharp differentiation of the epithelial cells showing their physiological endocrine changes but in other secretions we use the simple H & E stain although in some instances we have found that the Papanicolaou stain gives perhaps superior histologic detail.

Dr. N. Chandler Foot (closing): Training of young men is a very important thing, but naturally I am not propagandizing training courses in our laboratory. We are giving preference to pathologists, (I do not think it is indiscreet for me to say so, naturally we should); in second line to gynecologists, who because of their work, are very much interested in pathology and some of them are excellent gynecological pathologists, more trustworthy than the general pathologist.

One man came to our laboratory, the director of a very large and important laboratory in New York, and stayed two or three days and then threw up his hands and said, "There is entirely too much work here for me to institute anything like this in my hospital".

As to the relative methods of staining which Dr Pilot asked about, judging from your pictures in the Scientific Exhibit I should think you have mighty good ones. The Papanicolaou method is chiefly valuable because most of the solutions are in alcohol and it adds to the transparency. That is one of the reasons it is good. Another reason that the stains are good is that he is inclined to include Orange G which is useful in gauging the amount of keratin present in cells. I do not hold, and I do not think that he holds, any brief for using his stains. He has over 200 of them, and a great many of them are closely guarded top-drawer formulae. I think that the choice is, as I said, largely a matter of taste.

Hematoxylin and eosin is good. I think it falls down in the matter of keratinization and I am inclined to quote from one of our late professors of histology who was a foreigner and who said to the students, "Eosin is a splendid stain. It stains the nucleus, it stains the cytoplasm, it stains the towels, it stains *peanuts.*" You have a stain which is too diffuse; I mean is a litte too diffuse. It is very apt to stain the background, the extraneous material, and you do not get such clear detail.

Personally, and I say this somewhat guardedly, I find the Shorr stain is an excellent one; it brings out very good details. It is a modified Masson which is applicable to smears and which gives you a color scheme to which there is a background of green of which I am very fond. A very nice stain. But the whole matter of stains depends on getting a good transparent one that will bring out the nuclear details accurately and I do not think it much matters what you use.

Incidentally, the very simple fixative of alcohol and ether is surprisingly good.

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## A CAUSE FOR BACKACHE

In recent years several investigators have called attention to the importance of fat tissue in the subfascial spaces as factors in painful syndromes. Our former concept of fibrositis as a clinical or pathological entity involving muscle or fibrous tissue has been dispelled by the discovery that the painful lesions which were interpreted as "fibrositic" nodules are, in reality, masses of fat tissue which have undergone changes and are causing varying degrees of disability. *Excerpt: Subfascial Fat Abnormalities and Low Back Pain, R. J. Dittrich, M.D., Duluth, Minnesota, Minnesota Medicine, June, 1950.*

# Medical Problems in Psychiatric Patients

**Frank Garm Norbury, A.M., M.D., F.A.C.P.,**
**Jacksonville**

My own contacts with the state hospitals of Illinois probably are chronologically longer even though not as active as those of you here today. Born at the Jacksonville State Hospital, living there and at the one at Kankakee, visiting most of the hospitals at one time or another, either personally or professionally, I have many pleasant associations with the Department and the institutions represented here. The work of Dr. Singer at the Psychopathic Institute in Kankakee, the opportunity to be around the laboratory and see some postmortems by Dr. Bybee of the staff there probably had as much to do with my studying medicine as anything else. Later laboratory and medical training, perhaps stemmed from those early stimuli, have influenced an approach to neuropsychiatry that still tries to correlate or integrate various dysfunctions that are seen in patients.

Recent years have brought about a modification of this approach in an attempt to follow more the teachings of Dr. Adolph Meyer in his psychobiologic approach. His former laboratory in the tower of the Kankakee State Hospital was the photographic section when we lived there. I shudder to think of some of the photographic crimes I committed there but even at that there could not help but be some stimulation from some of the duplicate material that was still around on shelves and in cabinets.

One of the most recent and most intriguing phases is in connection with the newer field of cybernetics or control and communication in the animal and the machine. It appears to offer the most nearly satisfying explanation of a non-metaphysical nature as to the connection between neurophysiology and psychic functions. While as yet it is tied in with higher mathematics, the Boolian system of algebra and the so-called mechanical brain, it has in my opinion definite implications for neuropsychiatry. Hoagland's paper "Rhythmic Behavior of the Nervous System"[1] and Weiner's monograph, "Cybernetics"[2] are two of the most stimulating and thought provoking publications I have read in the last few years. The chief trouble is that they call for more knowledge of mathematics, physics, and semantics than the busy doctor in state hospital or private practice has had in the past or has time to study for in the present. Nevertheless work in such direction has in my opinion most definite implication for future knowledge and understanding of what is going on in the minds and bodies of our patients and ourselves. A comparable future path lies in the direction of another electrochemical mechanism, the enzyme systems.

It would be easily possible in discussing the title of this paper to go through various headings alphabetically such as from abscess to zinc sulphate poisoning. It is believed though that such is not the intent of those who asked me to come here. It is certainly not in keeping with the thoughts expressed above and with the idea of an attempt at integration or correlation of these medical problems with the psychiatric disorder that necessitates treatment.

Many problems have to do with circulatory insufficiency in brain, heart and kidneys. Particularly does this apply in neuropsychiatry as the increased number of patients with cerebral arteriosclerosis occupy more and more beds in hospitals of all types. The patient load is terrific, the load on the patients, their families and the state equally so. Yet a lot can be done for many of them. We all know that simply managing the situation in a controlled environment often makes a lot of difference. An explanation that has been found helpful in talking with relatives and, as things quiet down, with the patients themselves follows a familiar example. Cerebral arteriosclerotics are in much the same position in relation to the environment as persons who cannot swim. They get along fine in shallow smooth water, enjoy the simple proce-

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**Read before the Physicians Association, Department of Public Welfare, Illinois State Medical Society Meeting, Springfield, Illinois, May 24, 1950.**

dures they can follow. However, when rough waves (situations) arise or they get into something over their heads they are immediately in serious trouble. They are in danger themselves and may endanger others. If help is not promptly given, resuscitation applied when necessary, tragic outcome may develop rapidly.

There are certain medical measures of help, even of resuscitation for these people with circulatory insufficiency that are of great value. Fluids, food and attention to elimination are self-evident yet deserve some comment. Nasal feeding is in my opinion more humane and more expeditious than trying to hold a restless patient either manually or by sedation long enough to get adequate intravenous alimentation taken care of. Relief of a rectal impaction and clearing out the accumulated fecal material lessens a superimposed toxic absorption remarkably. An indwelling catheter, with manual restraint (frowned upon I know by the Department of Public Welfare) to see that it stays indwelling, relieves a distended bladder, hydroureter and hydronephrosis thus helping restoration of remaining nephron units.

Drug medication is not of great importance for these patients save for two things (1) avoidance of oversedation, (2) digitalis. Whereas younger individuals tolerate bromides and barbiturates pretty well the arteriosclerotic ones do not. Enough barbiturates to have a sedative effect make for unsteadiness on the feet with greater danger of falls and fractures. Bromide intoxication develops much more rapidly where there is impaired kidney function from arteriosclerotic or other causes. This was summarized in a paper before the State Medical Society in 1946.[3] We like chloral with perhaps a small amount of bromide for these patients.

Sir James Mackenzie years ago and Christian later stated that digitalis in small maintenance doses even in the absence of the usual signs of failure helped improve myocardial efficiency. Though this view has been controverted by some who feel that it is only of value in impending failure, failure, or post-failure situations, clinical experience seems to sustain it. Naturally with failure of either primarily congestive or anginal type digitalization is indicated. It is desired, however, to make the point that a lot of these patients give the impression to the observer that they think better when on digitalis than when off it.

The acid-base mechanism and mineral utilization need to be mentioned along with the circulatory discussion. There are some practical and relatively easily managed phases here that do not call for specially prepared diets that are difficult to have in large groups. The emphasis on the low salt management and the importance of sodium as brought out in recent years has changed dietetic points of view. While salt meats, and salt pack vegetables are cheaper, keep better and to many are more palatable than the unsalted products they are not nearly as much a part of the diet for chronic hospital patients as they were even a few years back. The salt substitutes are still relatively expensive though cheaper than when first brought out. Those on the market now are non-toxic. Ammonium chloride is a good salt substitute, is cheap, is not toxic in usual amounts, has a mild systemic acidifying effect which stimulates urinary excretion. It has been found helpful in many instances quite aside from its use as an expectorant or in connection with mercurial diuretics. The fact that sodium is present in other preparations besides table salt must be kept in mind. Sodium bicarbonate affects both mineral and acid-base mechanisms. Alkalosis with or without tetany can come on in the patient with some arteriosclerotic kidney change along with the cerebral arteriosclerosis. Two of the most marked toxic deliria I have ever seen were in older ulcer patients who had developed the habit of liberal use of soda bicarb for their ulcer symptoms. Lessened renal output, non-protein nitrogen retention, hypochloremia looked bad but cleared up promptly under treatment as did the delirium. Now that the non-absorbed alkali preparations and the adsorbent colloids are used so widely in ulcer management there should be less of this sort of thing.

It is of some interest in connection with the gastric situation just mentioned that achlorhydria is found to increase in frequency in the later years. Bennett and Ryle[4] and Hurst[5] state that 4 per cent of the population are achlorhydric and that in 6th and 7th decades the percentage is higher. There is still another angle to this question. Many depressed persons, many schizophrenics show lessened gastric acidity and secretion but secrete acid with histamine. A paper

twenty years ago before the State Society brought out the fact that with improvement of the nervous or mental condition the gastric response increased.[6] It would be entirely speculative to say whether this is cause or effect. It is believed there is some linkage there with a present interest in hypothalamic mediation. Suffice it to say that we prescribe dilute hydrochloric acid much more frequently than we do alkali, even with a fair number of psychosomatic ulcer patients for whom the latter is used. Some of this is given on the basis of gastric analysis, some on the knowledge that the much used and highly valued vitamin-B complex is not as well absorbed and utilized without free HCl being in the stomach and some just on "hunch."

Other metabolic phases have to do with diabetes, the anemias, the vitamin deficiencies. We have all seen neuropsychiatric patients who have gained markedly in weight, perhaps developed diabetes, just as non-neuropsychiatric patients do. Polyphagia there may be a manifestation of nervousness, it may be an attempt at oral satisfaction. Whatever the underlying factor may be it is important to look out for the diabetic state. Arteriosclerosis develops earlier, progresses more rapidly in the diabetic. We hold with the low fat diet program based on the work of Joslin and his associates,[7] also the pathological and experimental studies of Leary.[8]

On the other hand anemia and deficiency states are really more common in psychiatric situations. Withdrawal, rejection are motivating factors in lessened appetite or perhaps complete refusal of food. While nasal feeding as indicated above will take care of caloric needs, any accompanying anemia, which is usually of the nutritional, iron deficiency type needs attention too. I used to think that thiamin was the more important member of the B group for these people. I now consider niacin and pyridoxin rate equally with it.

I have tried in this paper to bring out some general features that I have found helpful in the care of patients. The most important thing of all is that we are dealing with sick individuals who have personality problems and distortions. Whether these are of so-called psychogenic or functional or organic, or physiologic, or anatomic origin is quite beside the point. Whether the situation is an acute emotional upset of short duration, a long-standing schizophrenic reaction or a senile, second childhood, we see a sick patient. The illness may have medical or surgical concomitants in its origin. Measles, appendicitis, a broken leg, or a lot of other things may happen to that person during the course of the mental illness. They might happen to us too. We want good medical help for these people just as we would want it for ourselves. The large amount of clinical material, even with the patient load each of you carry offers a great chance to learn a lot about people and a lot about medicine. That is good for you and good for all of us as citizens and physicians.

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# Kwashiorkor — And Cirrhosis of Liver

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*Dr. Robert M. Kark*: One might question the advisability of discussing a disease so exotic that its name is unfamiliar to most of us. I believe that such a symposium is indicated when we can learn a lesson about common diseases of temperate climates through comparison with rare conditions. Kwashiorkor actually is a disease of widespread tropical geographic distribution. It has been noted in southern Mexico, Malaya, Puerto Rico, India, and Central Africa among other places. It is a fulminating nutritional deficiency related to diet, climate and the spectrum of other tropical diseases, endemic concomitantly with Kwashiorkor. The name of this disease is "Kwashiorkor" from an African tongue and literally means "red boy" because of the characteristic associated dermatitis. Another tribe has a name which when translated means: "the-disease-the-first-child-gets-when-the-second-child-is-born." This is understandable when the tribal custom of weaning children only after they are three to five years of age is pointed out. Thus, the nutritional deficiency develops after the first child is weaned because the second child is put to breast and the first child gets no more milk. Certain tribes in endemic areas appear immune to this disease. Analysis of their eating habits reveals that some of these drink cow's blood while others eat fish, habits unshared by the affected tribes. Malaria, schistosomiasis and amebiasis and other infestations are rampant in the areas where kwashiorkor exists. Early symptoms of this disease include apathy, edema, umbilical hernias, potbellies and, later, changes in hair and skin. The normally curly coarse peppercorn hair becomes straight, fine, thin, and reddish yellow. Tufts of alopecia appear. The normally jet black skin of the native becomes reticulated. It peels, and a patchy black and white surface remains. The skin looks like black paint which has flaked off woodwork. The salivary and lachrymal glands enlarge. The tongue becomes edematous, smooth, and easily indented. Peristalsis is increased and the affected natives have greasy slimy stools. The pancreas is involved. Occasional xerophthalmia is noted and rarely, rachitic manifestations. Other findings include anemia, neurologic changes, similar to those of beri-beri, and paraesthesias. Laboratory studies reveal a very low serum albumin and often a macrocytic or a normocytic anemia. These people usually die of acute dysentery, tuberculosis, or pneumonia. In endemic areas this disease is not extremely common but mild forms are frequently seen and residues of the disease are noted in many adults. Residues include especially cirrhosis of liver in many but not all tribes. Hepatomas are common. Other late manifestations include carcinomas of the male breast, salivary gland and reticulo-endothelial system, including Hodgkin's disease. There is a definite tendency to feminization of the male with gynecomastia. Hemosiderosis is commonly present. The cirrhosis is believed related to the type of secondary infestation. To us the most interesting aspect of this condition is the late cirrhosis of the liver. We would like to compare the cirrhosis of kwashiorkor with the Laennec's cirrhosis seen in the United States. It is felt by many that alcoholic cirrhosis is a purely nutritional disease. We question this. We believe that alcohol and its metabolic products

might have an effect similar to that of schistosoma infestation when superimposed on a nutritional fatty liver. Further histologic study of these cases might help to elucidate this point. Dr. Pirani is at present making such a study and will elucidate his findings.

*Dr. Conrad L. Pirani*: Cirrhosis of the liver is an intriguing clinical and pathologic entity. On examining a given liver section one often cannot say whether the cirrhosis is atrophic (alcoholic), post-necrotic, or biliary in origin. Recently through the courtesy of Dr. J. N. P. Davies, Pathologist at Kampala, Uganda, we have been able to study histologically the tissues from a number of autopsies as well as several liver biopsies from patients with Kwashiorkor.

In children under five years of age we have noted fatty infiltration of the liver localized quite regularly in the peripheral portion of the lobules. The Kupfer cells especially in the areas of fatty metamorphosis contained granules that appeared to be malarial iron pigment. The spleens were enlarged with malaria. The pancreas exhibited atrophy and disorganization of the acini; the islets of Langerhans were prominent. The G.I. tract was not remarkable. As the disease progresses, the fatty changes reach the center of the lobule. In children more than five years of age the fatty degeneration appears much more severe, the number of lobules affected is increased and there is perilobular fibrosis. With the progress of the cirrhotic process, the fatty infiltration diminishes. This is quite comparable to what we think is the normal process of development of alcoholic cirrhosis in the United States. In the older age groups necrosis of the lobules appear in some areas resembling the early stages of toxic cirrhosis seen here. Histologically, there is only a limited hepatic cell regeneration but the incidence of carcinoma of the liver in these patients is quite high. There are also changes in the skin and kidney. The skin shows follicular keratitis and atrophy of the collagen. There is increased cellularity of the renal glomeruli. The spleen shows malarial pigment as well as hemosiderin.

Several intriguing questions are raised by this study. (1) Are the pancreatic changes a primary factor or are they a consequence of the fatty liver? Certainly the diarrhea which these patients have seems to be of pancreatic origin. The large islets of Langerhans are perhaps correlated with a failure of the liver to store glycogen. (2) What is the role of the pigment in the production of fibrous tissue? We do not have the answer to these questions.

*Dr. Kark*: Co-existent findings of cirrhosis and pancreatic calculi have been noted in alcoholics. In these cases, 30 to 60% of the stool is fat.

*Dr. Emanuel Farber, Hektoen Institute*: In Dr. Popper's laboratory we have been interested in the effects of ethionine and methionine on the liver. Ethionine will produce a reversible fatty infiltration of the liver and we have also noticed along with it diffuse fatty necrosis of the pancreas, very similar to that shown to us by Dr. Pirani in the cases of kwashiorkor. There is a dilatation of the ducts and an inspissation of eosinophilic material. If the changes are very acute there is a vacuolization with some acinar cell degeneration. Phosphorus intoxication is also characterized by fatty degeneration of liver and pancreas. Is this condition the proximal convoluted tubules of the kidney are also involved.

*Carroll L. Birch, M.D., Professor of Medicine*: Are leg ulcers characteristically seen in this condition? In my experience going through the Congo and the Cameroon, most of these individuals have had leg ulcers. I should also like to report the story of one native who had liver involvement with marked ascites for whom the missionary doctors had been of little benefit. After treatment by native herbs of an unknown type, his ascites disappeared.

*Dr. Kark*: As far as the leg ulcers are concerned they do not occur in Uganda. It has been reported that they are seen in some cases of kwashiorkor in India. We would certainly like to know what was contained in the native herbs.

*Dr. M. M. Montgomery, Assistant Professor of Medicine*: Do you have any idea why hepatomas are found in an inordinately large percentage of Bantus (African natives) with cirrhosis?

*Dr. Kark*: The hepatomas in the tropics appear to be related to bilhariza with an associated nutritional deficiency. The pigmented people seem to be prone to hepatomas. We have not

(*Continued on page 297*)

# Methemoglobinemia in Infants

**Springfield**
**A. R. Eveloff, M.D.**

Shortly after Comly's[1] report of two cases of methemoglobinemia in young infants resulting from the ingestion of water containing excessive amounts of nitrates, it became apparent that this condition may have been the explanation of the cyanosis in a number of cases which we previously suspected of having congenital heart disease, intracranial hemorrhage, abnormalities of the respiratory tract, or even enlarged thymus. Once our attention was focused on this possibility as a causative factor in cyanosis, we were surprised at the relative frequency with which it occurred. The purpose of this paper is to present a group of 25 such infants who were admitted to the Springfield hospitals during a period of approximately two years.

Because of the similarity of the histories, physical findings, and subsequent course of these patients, no attempt will be made to present individual reports. Instead, there will be a resumé of the average case, with a detailed report of one of the more unusual ones and those of the two babies who did not survive.

The first point is that all of these infants came from rural homes in which a well, in most instances an unsatisfactory one, was the source of the water. The second point is that all of these babies were on artificial milk formulas, either evaporated or a powdered form of milk. In all instances, birth history was within normal limits, and although a number of the babies were breast fed for varying periods, within a matter of several weeks, breast feeding had proved inadequate. The first symptom noted in all cases was cyanosis, which as a rule was gradual in its onset with progress in degree varying, though in several instances the cyanosis apparently appeared suddenly, approaching alarming proportions rapidly. Diarrhea was absent in the larger number of the patients, as was fever. Respiratory distress was noted frequently. After the first several cases, the diagnosis was made fairly quickly. The treatment varied. A number of the babies were given oxygen and nothing else. In several instances intravenous methylene blue was administered with dramatic results. Oral methylene blue was used a few times. We did not employ ascorbic acid.

Baby S. was first seen at the age of two months. He had been entirely well until the afternoon of admission, at which time blueness of the lips and rapid respirations were noted. The baby was given oxygen, but without apparent help. On crying, his color became a jet black, which cleared to a slate grey, when the patient was quiet. Birth history was normal. The baby was receiving an evaporated milk formula, prepared with water obtained from the family well. The interesting point about this child, is the fact, that on the day the cyanosis was noted, the parents had taken the baby to visit the grandparents at a nearby farm. The formula for that day was prepared with water obtained from the grandparents' well. The nitrate content of the water from the home well was found to be 137 parts per million; that of the grandparents' contained 1050 parts nitrate per million. In this instance, the baby was apparently able to tolerate the contaminated water with the lower nitrate content, but manifested severe methemoglobinemia after taking a relatively small quantity of the water containing the unusually large amount of nitrate.

Of the two patients in this series who died, Baby F. was an 18 day old infant, who had had a normal delivery. Breast feeding was attempted for about a week but was unsuccessful, and an evaporated milk feeding was started before hospital discharge. The course was then without concern until about twelve hours before re-admission. At that time, blueness was first noted with rapid progression in degree, and difficult

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**Presented before Section on Pediatrics, 109th Annual Meeting of Illinois State Medical Society, Chicago, May 17, 1949.**

respirations. Soon after the onset of symptoms, a local physician made a diagnosis of enlarged thymus. By the time the baby was brought to Springfield, he was extremely cyanotic and the respirations were gasping in character. Venous blood was found to have a deep chocolate coloration. Oxygen and stimulants were of no avail. Death occurred before methylene blue could be given. It is interesting to note that this family had lost another young infant just over a year ago. The history in that instance was identical with that of this patient. The cause of death then was thought to be hypertrophy of the thymus gland. Post-mortem findings in our patient showed all the internal organs to be a chocolate brown color. The heart was markedly dilated and filled with chocolate brown blood. Analysis of the water used for the baby's formula showed that it contained 135 parts of nitrate per million.

Baby E. was first seen at the age of 46 days. Again, birth history was normal. Breast feeding was not attempted and a powdered milk formula was used. Water for the feeding was obtained from an old well located in close proximity to the barn. At the age of three weeks cyanosis was noted. This cleared up following admittance to a hospital where oxygen was administered. Subsequently, the baby was discharged after receiving x-ray treatment for an enlarged thymus. About ten days later the cyanosis recurred, and again the child was hospitalized and treated for hypertrophy of the thymus. Once again, at the age of 44 days, cyanosis returned and became progressively more intense. The baby was brought to Springfield after 48 hours in a critical condition. The skin color was blue black and respirations were extremely shallow and irregular. While methylene blue was being prepared, respirations ceased, but returned with stimulation and artificial respiration. Methylene blue was then given intravenously with apparent improvement in color. However, this was temporary and within a short time the patient expired. The post-mortem findings were similar to those previously described. The nitrate content of the well water was found to be 350 parts per million.

## COMMENTS

Although there have been several reports in the literature of cyanosis due to methemoglobinemia of unknown cause, the case recorded by Rector and Schwartz in 1942 was perhaps the first, which in retrospect, must have been an instance of nitrate poisoning, resulting from the ingestion of contaminated well water. Since Comly's paper, further reports have been published—Ferrant[2], in Belgium; Faucett and Miller[3], from Kansas; Medovy, Guest and Victor[4], in Winnipeg and Donohoe[5] from South Dakota, suggesting that this condition is not peculiar to any locale, but may occur anywhere that contaminated well water is used for preparation of infant formulas.

It has been stressed, that the very young infant is the most likely to develop significant methemoglobinemia from this cause. With this in mind, it is interesting to note that several of our patients were in the two month age group, and one baby was 82 days old at the time of hospital admission. Of necessity, the age given is that of hospital admission, although it is recognized that the presence of cyanosis must have been noted for a varying time, preceding hospital entry. The youngest patient in this group was 14 days of age, with the larger number falling into the 3-4 week old level.

The relationship of the quantity of nitrate present in the water used by the patients in this series, to time of onset and degree of symptoms, was not completely definite. Nitrate determinations were made in all of our patients with a marked variation in the total amounts recorded. The lowest figure was found to be 99 parts per million with the highest 1050 parts per million. Comly's report mentions a survey of some 2000 Iowa farm wells by the Iowa State Planning Board, showing a varying nitrate content from zero to 125 parts per million. The standards of safety set by the U.S. Public Health Service allows for not more than 10 parts nitrate per million. Water containing 10 or more than 15 or 20 parts nitrate per million is considered potentially unsafe for infant consumption.

Methemoglobinemia may follow the administration of such chemicals as analine, nitrophenol, sulfanilamide, potassium chlorate and nitrates. That nitrates may be associated with serious or fatal methhemoglobinemia in infants has been realized since bismuth subnitrate first was used as a constrast media by roentgenologists. Roe[6] in 1933 reported the death of a one month old infant with diarrhea who had received 0.6 grams of bismuth subnitrate every two hours, until the stools became black. Cy-

anosis occurred in 24 hours. Thirteen grams of the drug was given in 44 hours, and despite oxygen therapy, death occurred 60 hours after the drug was first administered.

Nitrate methemoglobinemia in adults has been reported less frequently. Eusterman and Keith[7] administered ammonium nitrate orally for diuretic purposes to a large series of adults. Two patients developed methemoglobinemia. In one, extreme cyanosis occurred when 54 grams was given over an eight day period. These workers gave ammonium nitrate intravenously to dogs and failed to produce methemoglobinemia. They concluded that the nitrate ion was transformed to nitrite by some abnormal metabolic process present in the two patients, both of whom had intestinal stasis.

Van den Burgh[8] in 1905 indicated that nitrites could be formed in the intestinal tract from nitrates and that the absorption of the nitrite ion was encouraged by the presence of damaged intestinal muscosa. Comly suggested that the nitrate ion was probably converted to the nitrite form in the intestine by bacterial action. The nitrite ion, so formed, was absorbed and reacted with hemoglobin to form methemoglobin. Medovy, Guest and Victor offer the following explanation: when nitrates are ingested or produced in the intestinal tract, they are not absorbed but are reduced to nitrites, and then to ammonia and excreted as such. In the presence of greatly increased quantities of nitrates, such as follows the ingestion of drugs or of water with a high nitrate content, it is possible that the nitrites have insufficient time to be completely reduced and so reach the circulating blood and thus form methemoglobin.

More recently, Cornblath and Hartmann[9] have been able to demonstrate that factors other than the quantity of nitrate ion ingested by young infants are instrumental in producing cyanosis. Giving as much as 100 mgm. of nitrate ion per kilogram to a group of four infants failed to produce cyanosis. However, in the presence of nitrate reducing bacteria in the upper gastro-intestinal tract as was evidenced in the babies who had previously developed methemoglobinemia, cyanosis readily occurred. They concluded that only infants who have a gastric pH higher than 4.0 and nitrate reducing bacteria in the upper gastro-intestinal tract develop methemoglobinemia from oral ingestion of water containing nitrates.

It seems apparent, from our observations that the quantity of nitrates ingested must play an important part, both in the initial occurrence of the cyanosis, and probably the degree of cyanosis. It is further likely that the nitrate reducing bacteria are introduced into the gastro-intestinal tracts of these infants by the ingestion of the contaminated water, and the greater the numbers of such bacteria the more severe will be the cyanosis, perhaps because the conversion of nitrate to nitrite occurs at a more rapid rate. The presence of a favorable gastric PH must be a necessary accompanying factor.

A noteworthy finding in our series, was the fact that the frequency of cases decreased considerably during the second year. This, we are certain, is in no small degree a result of the efforts and interest of the Division of Sanitary Engineering of the Illinois Department of Public Health. Following the discovery of the relationship of ingestion of contaminated well water and the production of cyanosis, a total of 5660 samples of water[10] from private water supplies of all types and from all sections of the state were examined for nitrate content. Of these, 20 per cent had a nitrate nitrogen content of more than 10 parts per million. This total included a large number of samples of low nitrate content from the Northeast quarter of Illinois, where rural water supplies are generally obtained from drilled wells in the glacial drift or from limestone formations. In the rest of the state, where most rural water supplies are obtained from relatively shallow dug or driven wells, waters with toxic amounts of nitrate were found to be more common. In Sangamon County, more than 40 per cent of the waters from rural wells contain more than 10 parts per million of nitrate nitrogen, and 25 per cent contained 100 parts per million or more of nitrate. This finding must explain the relatively large number of cases occurring in our area.

## SUMMARY

Twenty-five cases of methemoglobinemia in young infants due to the ingestion of well water containing a high nitrate content are reported. These cases are actually cases of nitrite poisoning.

There were two deaths, a mortality of 8 per cent. The histories of these two cases strongly

suggest that an earlier, correct diagnosis would have prevented these fatalities.

Treatment consisted of oxygen therapy. I. V. administration of methylene blue, in the dosage of 1.0 - 2.0 mg. per kilogram. Oral methylene blue was given in several patients.

The frequency of this condition was found to be decreased in the second year of this study.

The poor quality of the wells in the Sangamon County area, as shown by nitrate content determination of samplings, by the Illinois Dept. of Health, probably accounts for the relative frequency of the problem in this area.


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DISCUSSION

Dr. Eugene T. McEnery, Chicago: This is one of the queer things which comes up now and then and you wonder why babies are blue? In the Chicago area, we have had in the past year two cases at the Children's Hospital in which babies were blue. They weren't blue from the fact that they had had water from contaminated wells but they were blue from the fact that they had had bismuth subnitrate in a diarrhea preparation. It is rather amazing how quickly this condition comes on. Two children had only had a medication, I think, of three doses. These babies when admitted had cyanosis which looked little different from a congenital heart condition, and responded very well to the treatment Dr. Eveloff outlined. We have to keep in mind that this can occur from very, very small amounts of nitrate in medication or in the water.

It certainly is very interesting to know that this subject is being carried to the communities in which they may have wells that have a high nitrate content.

Is there anybody who cares to discuss this paper or to add anything to it?

Dr. A. R. Evelhoff: Blood methemoglobin determinations were done in several of our cases. The results obtained varied from seven to fourteen percent. The latter level was the highest obtained despite the fact that the degree of cyanosis in these babies was very severe. These findings were not in keeping with those reported by other workers.

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## Kwashiorkor — And Cirrhosis of Liver (cont.)

noted hepatomas occurring in our white cirrhotics.

*Dr. Montgomery*: Ten years ago at the Cook County Hospital 54 cases of carcinoma of the liver were studied out of a total of 13,000 autopsies. Most of these were on white people. In the Chinese hepatomas appear to be related to the liver fluke.

*Dr. Pirani*: South African cirrhosis seems to be somewhat different from that observed in kwashiorkor. There is a greater deposit of iron pigment, not necessarily malarial, deposited and a much higher incidence of carcinoma.

*Dr. M. Samter, Assistant Professor of Medicine*: Is hemosiderosis common in all African natives?

*Dr. Kark*: It appears to be common in South Africa. It is probably related to the quantity and balance of calcium and phosphorus ingested. These natives eat a relatively high phosphorus diet.

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

# Familial Hereditary Hemorrhagic Telangiectasia in the Negro

## Report of a Second Case

**William H. Kleinschmidt, M.D. and Steven O. Schwartz, M.D.**
**Chicago**

In 1948 we reported a case of familial hereditary hemorrhagic telangiectasia (Rendu-Osler-Weber disease) in the Negro.[1] A second case has recently been observed by us, emphasizing the fact that the frequency with which unusual conditions are found is in direct proportion to the diligence of the search for them.

At the time of her first hospital admission to the Cook County Hospital on October 7, 1939, the patient was 26 years old. She had had epistaxes once or twice a week since childhood. These had increased in the preceding two months so that they were occurring once, and occasionally twice, daily. For two weeks she noted low back aches mostly at night, a dull aching pain over the precordium especially with deep inspiration, and right temporal headache occasionally relieved by the epistaxes. Of further interest in her story were the findings of bright red blood in the stools with prolonged epistaxes; dyspnea, ankle edema and heart consciousness on occasions; a recent loss of 20 pounds; and "shots for bad blood" in 1930.

She was a well developed negro female, not acutely ill. Temperature 99.2°F., pulse 108 and regular, respiration 24, blood pressure 134/80. Fresh blood was flowing from the nasal septum. Hemorrhagic areas were seen on the back of the tongue. The left heart border was one cm. outside the mid-clavicular line at the sixth interspace, and a systolic murmur was heard at the apex. A few days after admission "petechiae" were found on the tongue, pharynx and conjunctiva.

Urinalysis was negative except for a + albumin. Erythrocytes numbered 3.51 million, hemoglobin 57% (8.8 gm.), leukocytes 5,000;

From the Hematology Laboratory and the Hektoen Institute for Medical Research of the Cook County Hospital, Chicago.

Aided by grants from the Edward Friedman Foundation, Olivia Sue Dvore Foundation, and the Wilson Laboratories, Chicago.

neutrophils 44%, eosinophils 2%, lymphocytes 51%, and monocytes 3%. The red cells showed slight polychromatophilia, hypochromia, anisocytosis and poikilocytosis. Bleeding time was three minutes. The Rumpel-Leede test, an electrocardiogram, the blood non-protein nitrogen and the Kahn test were all normal. Two blood cultures revealed no growth. Roentgenogram of the chest was normal except for a slight increase in hilar markings. The diagnostic impression was rheumatic heart disease, with a possibility of a complicating subacute bacterial endocarditis or thrombocytopenic purpura. She was discharged on October 18, 1939 with a diagnosis of rheumatic heart disease.

On November 2, 1944 she was readmitted to the hospital with an Admitting-Room diagnosis of luetic heart disease. She complained of pain in the chest, vertigo, epistaxes, dyspnea, orthopnea, palpitation and ankle edema for a month. Weakness and occasional headaches began three weeks before admission. Three days before admission she developed nausea and vomiting. Bright red blood was again noted in the stools whenever she had epistaxes, but the menses remained normal. There was also nocturia for a few weeks, and she had stopped smoking and drinking because she "couldn't stand it anymore." There was an eight pound weight loss in four weeks.

A chronological history taken at this time revealed the following: born a "blue baby" in Alabama; mother died postpartum; had epistaxes almost every day until the age of five or six and remained pale; confined to bed for three months with "rheumatism" at the age of eleven; came to Chicago at fourteen, after her father, who had a history of epistaxes all his life, died of a "bad heart." By now the epistaxes had decreased to once or twice a month. She married at eighteen, had no pregnancies, and lost her husband in a train accident. Headaches and occasional vertigo developed at 21. At 25 her epistaxes began increasing, and became so severe that she lost about a cup of blood each day.

At this time she was slightly dyspneic, her pulse was 120 and blood pressure 126/0. "Petechiae" were noted in the left lower conjunctiva. The heart was normal in size and a systolic murmur was present at the aortic, pulmonic and apical areas with a questionable diastolic murmur at the aortic area. The liver was one to two fingerbreadths below the right costal margin in the mid-clavicular line.

The erythrocytes now numbered 1.04 million, the hemoglobin 10% (1.5 gm.), leukocytes 6,100. The epistaxes continued and she was given 500 cc. blood two days later and placed on iron therapy. Four days after admission the blood pressure was 130/65, the murmurs were less intense and no aortic diastolic murmur was audible. "Petechiae" were seen in the right lower conjunctiva six days later. Rheumatic heart disease, possibly with subacute bacterial endocarditis, or thrombocytopenic purpura were again considered. Another 500 cc. blood was given on November 8, 1944. Free acid was found in the gastric contents only after the administration of histamine. There was an increase in the size of both ventricles. The aorta appeared widened. An electrocardiogram revealed low voltage and a left axis shift. Blood cultures repeatedly failed to reveal growth of organisms.

Two weeks after admission the rhinologist reported bleeding from dilated vessels in Little's areas bilaterally. These were cauterized. At this time she had 2.85 million erythrocytes, 41% (6.3 gm.) hemoglobin, 8,000 leukocytes, and 1,469,800 platelets. The marrow revealed an increase in megakaryocytes, a nucleated RBC:WBC ratio of approximately 3:1, normoblastic erythropoiesis with a left shift and normal granulopoiesis. The mature red cells were filled with hemoglobin and tended to be macrocytic. These findings were interpreted as being compatible with long continued bleeding and an iron deficient state under treatment. By the end of the fourth week the values were: 3.45 million erythrocytes, and 55% (8.5 gm.) hemoglobin.

She was discharged on December 5, 1944 with the diagnoses of rheumatic heart disease and hypochromic anemia.

Her third admission to the hospital, on April 4, 1950, was necessitated by cough, dyspnea, ankle edema and increasingly severe epistaxes during the preceding two weeks. The epistaxes had been becoming progressively more severe during the three years past, and two weeks before admission she developed a "cold" which aggravated them. Hemoptysis and hematemesis now accom-

panied the epistaxes. She "filled a wash basin with blood" at the onset of her "cold" and on the day before her admission to the hospital. Her headaches, which were occipital, were more frequent than on the last admission. She complained of poor hearing which she attributed to a "roaring" arising in her neck. Tinnitus occurred between the episodes of "roaring." The tongue had gotten sore lately.

She was still well developed, moderately obese, weak, quite pale, but comfortable. A one to two mm. sized bright red area was found on the index finger of the right hand just distal to the metacarpophalangeal joint. Similar bright red areas were present on both anterior and posterior aspects of the tongue and the mucous membrane of the nose and mouth. These areas, which had always been interpreted as petechiae, were bright red, blanched on pressure, and were occasionally seen to pulsate under a glass slide. They had the typical appearance of telangiectases. The heart was enlarged and a grade III systolic murmur was heard over the entire precordial area, loudest at the apex. A few scattered inspiratory wheezes were heard over the lungs. The liver edge was six cm. below the costal margin. Pelvic and rectal examinations were negative.

Blood findings on this admission were: erythrocytes 1.24 million, hemoglobin 15% (2.3 gm.), leukocytes 14,700, neutrophils 78%, bands 6%, eosinophils 1%, basophils 1%, lymphocytes 12% and monocytes 2%. The erythrocytes were moderately hypochromic, anisocytic, poikilocytic and polychromatophilic. Bleeding and coagulation times were normal. Urinalysis, Kahn test and Rumpel-Leede tests were negative. Roentgenograms of the chest revealed the heart size to be increased both to the right and left. The blood non-protein nitrogen was normal; cephalin flocculation negative; thymol turbidity 1.8 and 1.9 units; gamma globulin 0.68 and 0.84 gm.%; albumin 3.3 gm.; globulin 1.9 gm.; cholesterol 143 and 157 mgm.; alkaline phosphatase 3.8 and 4.4 units; icterus index 5.

She was given blood, iron and Rutin, and was discharged two weeks later.

She was next seen as an out-patient on May 5, 1950. The telangiectases had increased in number, now being present on the right conjunctiva, both lips, most of the fingers, and the palm of the right hand. Fresh blood was present on the nasal septum but she denied nosebleeds since being discharged from the hospital. Her hematologic improvement was marked, the erythrocytes numbering 4.49 million and the hemoglobin 72% (11.2 gm.).

## DISCUSSION

This is the second case of familial hereditary hemorrhagic telangiectasia to be described in the Negro. It is of particular interest that the diagnosis was not established, in spite of a typical history and findings (recurrent bleeding, multiple telangiectases and suggestive history in the father) until her third admission. The telangiectases, though seen, were thought to be petechiae on the first two admissions. The cardiovascular and systemic findings, undoubtedly largely due to anemia, together with the bleeding history and the telangiectases mistaken for petechiae, led to the erroneous diagnoses of rheumatic heart disease and/or thrombocytopenic purpura on two admissions. The possiblity of a coexisting mitral regurgitation, in view of the history of rheumatic fever and the physical findings cannot be unequivocally dismissed. The high pulse pressure and the questionable diastolic aortic murmur on the second admission were at first interpreted as being due to aortic regurgitation, luetic or rheumatic, but when the blood pressure and murmurs changed, this hypothesis was dismissed. The history of bright red blood in the stools suggests the possibility of telangiectases in the lower gastrointestinal tract, although it may have represented swallowed blood.

As has been previously pointed out[2] the question of racial purity or Caucasian admixture is entirely inconsequential in the interpretation of this problem.

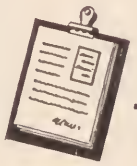
## SUMMARY

The second case of hereditary hemorrhagic telangiectasia occurring in the Negro is described. In view of the fact that the first case was seen within just a few years, it may well be that this is not as rare a disease in the Negro as was previously thought. It is of interest that the diagnosis was not made until the third hospital admission, in spite of a typical history and findings.

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# CASE REPORTS



# Maternal Pulmonary Embolism By Amniotic Fluid

**Charles Newberger, M.D.**
**Chicago**

The work of Steiner and Lushbaugh[1] in 1941, directed attention to the occurrence of pulmonary embolism by the particulate matter contained in amniotic fluid. They established the entrance of this material to the maternal circulation as a distinct pathological entity. To the eight cases they reported, they added two more in 1942[2]. Since then there have been published nine additional cases: three by Gross and Benz[3], and one each by Hemmings[4], Goodof[5], Watkins[6], Wyatt and Goldenberg[7], Shotton and Taylor[8], and a possible non-fatal case by Seltzer and Schuman[9].

The present case, reported by permission of the attending physician, is the twentieth on record:

The patient, 40 years old, gravida IV, para II, was scheduled for delivery on July 1, 1948. She had two living children, 4 years and 6 years old, and in 1946 had a spontaneous abortion of a twin pregnancy.

During the present gestation she was seen first at the seventh week, and then at twelve revisits. Wassermann was negative, urine was negative, blood pressure was normal; there was a weight gain of twenty pounds. X-ray two weeks before term showed the fetus in a transverse presentation. By external version, this was changed to cephalic presentation.

On July 1, 2 p.m., patient entered the hospital, not in labor, but because of her worry at being "overdue." X-ray reported a term infant, in occiput left anterior position, with head not engaged. Temperature was 98.2°, pulse 80, respiration 20, blood pressure 102/78, fetal heart tones 128. Medical induction was instituted at 4 p.m.: 5 grains of quinine hourly four times, followed by pituitrin every thirty minutes — two doses of one minim each, and six doses of two minims

**From the Division of Maternal and Child Health, Illinois Department of Public Health.**

**Presented at a meeting of the Chicago Gynecological Society, May 20, 1949.**

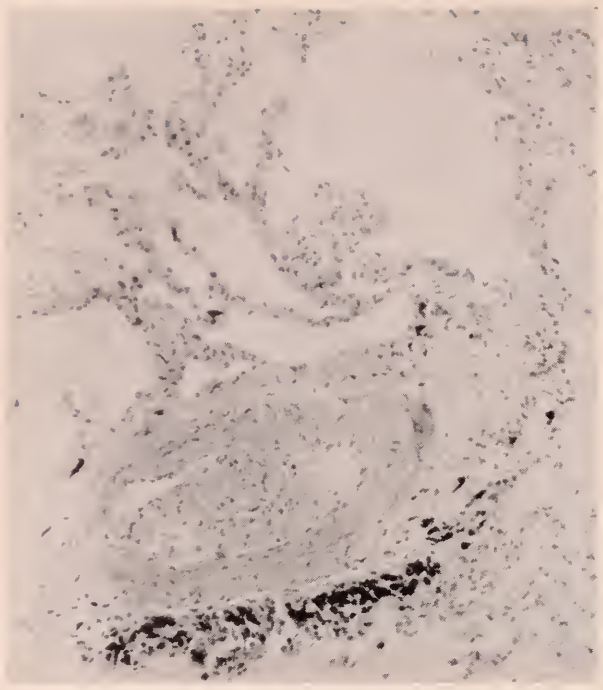


**Figure 1. Branch of pulmonary artery showing almost complete occlusion of lumen with masses of clumped hornified squamous epithelium. Low power.**

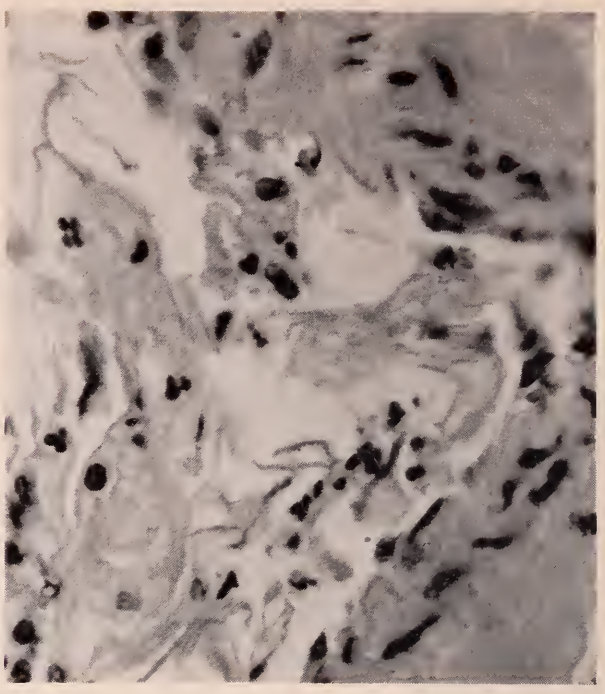


**Figure 2. Lumen of branch of pulmonary artery with isolated and clumped squamae. High power.**

each, the last dose being given at 11 p.m. Irregular contractions began July 2, 12:50 a.m., and by 1:30 a.m., they were at five minute intervals. At 2:15 a.m., the membranes ruptured; there was a large amount of dark, bloody discharge, and the patient was nauseated.

At 2:45 a.m., she had sudden twitchings of the arms, and became very cyanotic. She was given oxygen, coramine, adrenalin into the heart, and artificial respiration, but death occurred at 3:00 a.m., thirteen hours after admission to the hospital, two hours and ten minutes after the onset of labor, and fifteen minutes after the appearance of twitchings of the arms. At 3:05 a.m., a postmortem midforceps operation was done, with the extraction of a living seven pound seven ounce male infant.

A complete autopsy was done. Of interest are the lung findings: Grossly, there was no crepitation, no consolidation, no edema, no hemorrhage, nor were air bubbles recognized; in the visceral pleura, around the base of the heart, were pin-point asphyxial petechia. Microscopic sections from blocks of lung tissue, prepared by Doctor I. Davidsohn of Mount Sinai Hospital, Chicago, showed the lumen of many arterioles and capillaries filled with epithelial squamae, mucus, amorphorus debris, and blood cells, characteristic of the composition of emboli due to liquor amnii.

## DISCUSSION

A positive diagnosis of this obstetric complication depends on the microscopic demonstration in the smaller pulmonary vessels of emboli composed of the particulate matter of amniotic fluid. Helpful information in making the clinical diagnosis is suggested by a review of the twenty cases now on record:

1. It was more common in women of older age, — 8 of the patients were 35 years or older.
2. Multiparity was noted in 15 women.
3. The pregnancies were uneventful in 9 out of 11 cases where this information was available; one patient had 2+ albuminuria, and the other had a blood pressure of 170/120.
4. Hard labor was present in 12 cases, the contractions being designated as "severe," "violent," "powerful," "strong," "tetanoid." In another instance, a ruptured uterus was found at autopsy.
5. The character of the amniotic fluid on rupture of the membranes was given in seven cases: of these it was normal in only one instance, and

in 6, there was either blood and/or meconium.

6. The infant weight was above average. Out of 8 babies where the birth weight was recorded, 7 were from 8 pounds to 12¼ pounds. This fact may also suggest the possibility that pregnancy was of longer than normal duration.

7. Only 7 infants were born alive.

8. The onset of untoward symptoms was sudden and unexpected: in 6 cases during labor, and in 14 just after the delivery.

9. Profound shock was present in each case, with the following signs and symptoms listed according to their stated frequency: cyanosis, dyspnea, imperceptible pulse, restlessness, vomiting, chill, low or unobtainable blood pressure readings, rales, twitchings, and delirium.

10. The survival time after the onset of shock was from 5 minutes to one hour in 8 cases, from one hour to 5 hours in 8 cases, 8 hours in one, 11½ hours (?) in one, and 7 days in one case where the embolism probably was a contributing rather than the primary factor.


SUMMARY

A case of sudden death during labor due to pulmonary embolism by amniotic fluid is reported. Reference is made to 19 other cases in the literature, one of which was non-fatal. Findings in the 20 cases are reviewed which should be of help in making a clinical diagnosis of this rare obstetric complication.



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# Actinomycotic Brain Abscess


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This report is presented to exemplify the interrelations of pleuropulmonary actinomycosis and brain abscess. The interesting features are the complete recovery of the cerebral lesion following surgical attack and the marked resolution of the pleurisy under chemotherapy. This is the second case in the literature as far as we have been able to determine. A report by Schnieder and Rand[1] of recovery following complete excision of an actinomycotic brain abscess was the first case ever reported. Jacobson and Cloward[2] were the first to report a case of actinomycotic meningitis due to the acid fast aerobic nocardia asteroides that recovered with penicillin therapy.

J. H., a 55 year old white male of Greek extraction was first seen in the clinic on April 30, 1948 complaining of pain in the right upper quadrant of the abdomen, radiating to the chest, of one year duration. Two weeks prior to admission it had become increasingly severe and had caused anorexia, weakness and weight loss. The physical examination revealed dullness to percussion and diminished breath sounds over the posterior and axillary aspects of the right lower chest. There was resistance and tenderness in the right upper quadrant and a slightly enlarged nodular liver. Fluoroscopy and x-ray of the chest showed an elevated and fixed right diaphragm, diaphragmatic and parietal pleural shadows indicative of fluid and patchy infiltrations

1. Actinomycotic Brain Abscess, Complete excision with recovery. Schneider and Rand. Jour. Neurosurgery 6,255 May 1949.

2. Actinomycosis of Central Nervous System. Case of Meningitis with recovery. Jacobson and Cloward. JAMA 137,769 June 26, 1948.


**From the Neurosurgical and Chest Services, Michael Reese Hospital, Chicago, Illinois.**



**Figure 1. Roentgenogram on admission, showing encapsulated pleural fluid overlying the right diaphragm and extending upwards along the lateral chest wall.**

in the right lower lobe. (Figure 1.) , The diagnoses entertained were bronchogenic carcinoma of the right lung, chronic suppurative pneumonitis; lower lobe tuberculosis, and echinococcus cysts of the liver rupturing into the lung.

Four days later on his admission to the chest service of Michael Reese Hospital the findings were essentially unchanged except that he appeared drowsy and mildly incoherent. His temperature was 101.2, pulse 96, respirations 22, and the blood pressure was 130 systolic and 70 diastolic. There were no localizing neurological findings. On the morning of May 6, 1948 he was found comatose and could not be aroused. Later in the day he developed nuchal rigidity and tachycardia. The blood studies revealed hemoglobin 11.4 gms., red blood cells 4,000,000, and white blood cells 26,500. The blood urea nitrogen was 24 mgm. per cent. The urine was negative for albumin and sugar and no barbiturates were found upon chemical examination of the urine. The spinal fluid was cloudy, the pressure was 290 mm. water and after withdrawal of 3 cc it was 230 mm water. The cell count was 8 red blood cells and 3,980 white blood cells. The electrocardiogram showed "a rate of 200, regular, no P waves, S-T depressed in chest and limb leads, QRS up in leads one and two, and small and polyphasic in lead three. Low voltage; supraventricular paroxysmal tachycardia, and left axis shift. Definitely abnormal curve."

The following treatment was given: Crystalline penicillin 300,000 units twice daily; sodium sulfadiazine 2½ gms. intravenously followed by 1 gm. every four hours orally; streptomycin 250 mgm. every six hours. Following the administration of acetylocholine the pulse rate dropped to 120 but showed some irregularity. Quinidine grains 3 was then given every two hours until the rhythm became regular, followed by a maintenence dose. On the evening of May 6 nuchal rigidity became more marked, and suggestive Kernig and Brudzinski signs appeared, but no localizing signs. A portable x-ray of the chest suggested possible increase in the pleural effusion in the right lower chest. Aspiration, however, revealed no fluid but an extremely thickened pleura which was difficult to penetrate with the needle. On May 7 he was out of coma and rather alert; later in the day he complained of headache for the first time. On May 8 he was stuporous again and he could be aroused only by shaking. The nuchal rigidity was unchanged. The Kernig and Brudzinski signs were definite. The culture of the spinal fluid was negative after 48 hours. The neurological consultant reported the following: "The upper extremity deep reflexes are more brisk on the right than on the left. There is a definite plantar response on the right. There are no pathological reflexes. The right abdominal reflexes are present but are absent on the left. The patient is confused, and a detailed sensory examination is impossible. The facial movements seem symmetrical except for slight decrease in the left lower face. The pupillary findings are normal; the fundi are not visualized. Impression: A confused person with evidence of meningeal irritation and perhaps a right cerebral lesion, most likely non-infectious. One must consider the possibility, first, of a metastatic abscess, or a tumor from a pulmonary source."

On May 9 the neurological consultant reported the following: "Eyes showed no nystagmus; the movements were free and the pupils reacted to light. The fundi showed no papilledema.

Apparently a left hemianopsia is present. There is motor disturbance on the left side: it takes much longer to initiate movements with the left than with the right extremities. The movements of the left leg are weaker than those of the right leg; when it is raised passively it falls down. Impression: This is a process in the right half of the brain, probably in the parieto-occipital region."

On May 10 a spinal tap showed pressure of 290 mm water. Two cc were withdrawn with no drop in pressure. Red blood cells 1 to 2, white blood cells 231, Pandy was three plus, Ross-Jones was positive. On May 12 white blood count was down from 26,000 to 15,700. The temperature for the past four days had not been higher than 101.2. The skin tests performed with coccidiodin, blastomycin, O.T. 1-1000 and histoplasmin were all negative except for the O.T. which was positive one plus.

On May 13 the patient was again comatose and could not be aroused. His temperature was 99.6 to 100. The spinal tap showed cloudy, yellowish fluid and the initial pressure was 350 mm. water; the red blood cell count was 15 and the white blood cells count was 6,750; Pandy was four plus, and the Ross-Jones was positive. On May 14 the neurosurgical consultant concurred in the opinion that a space occupying intracranial lesion existed, and that an emergency craniotomy was indicated.

On May 15 an operation was performed under local infiltration. A subtemporal approach was made. The subtemporal bone was exposed and an opening was made approximately the size of a silver dollar. The brain was seen to be under tension. A small opening was made in the dura and a trocar was used to explore. At a depth of 5 cm. in the parietal lobe a large purulent abscess cavity was entered. Approximately 40 cc of pus was obtained. The cavity was filled with penicillin and rubber drain inserted. The incision was left open with iodoform gauze pack. The patient made an uneventful post-operative recovery. No residual, motor or sensory loss was evident. He continued to receive crystacillin 300,000 units twice daily up to two weeks before discharge, the total given was 36 million units. The total dosage of sodium sulfadiazine given was 5 gm. He received oral sulfadiazine for eight days, a total of 48 gms. Streptomycin had been discontinued after seven days, after a total dosage of 7 gms.

Pre-operatively all the cultures of spinal fluid had been negative for pyogens and acid fast bacilli. The direct culture of the purulent material from the brain abscess on Brewer's thioglycolate broth revealed a snow flake growth which was typical of Actinomyces bovis. On smear the organisms were revealed as gram positive, branching rods and filaments. (Figure 2). The organisms were not acid fast. The drainage from the craniotomy wound did not at any time yield the sulfur granules generally considered typical of actinomyces. All attempts to obtain material for culture from a chest tap were unsuccessful. A sputum specimen was not available because the patient did not cough or expectorate. A tracheal lavage was done but this material was also negative for fungi, acid fast bacilli and tumor cells. Suspecting that other foci of actinomycosis might exist, smears from tonsils and



**Figure 2. Smear of the culture from Brewer's medium stained by Gram's method, revealing tangled masses of branching rods and filaments typical of actinomyces bovis.**




**Figure 3. Roentgenogram taken eleven months post-operatively, showing almost complete resolution of the pleural fluid and patchy lesions previously seen in the right lower lung field.**

teeth were also cultured for Actinomyces bovis but these proved negative. The patient refused bronchoscopic examination. In view of the history of right upper abdominal pain gastro intestinal and gall bladder series were done in search of possible actinomycotic foci. No abnormalities were found. The x-rays of the paranasal sinuses and teeth also showed no abscesses.

He was discharged from the hospital on July 21, 1948 with no residual hemiplegia and normal fundi. He returned to work on November 30, 1948. When seen in the clinic on April 9, 1949 he had no complaints. He was free of cough and sputum. Fluoroscopy and x-ray of the chest (Figure 3) revealed better excursion of the right diaphragm. The diffuse density overlying the right lower lung field in the lateral aspect and the diaphragm had resolved almost completely. The patchy infiltration had also resolved considerably.

## DISCUSSION

Pulmonary actinomycosis is not a rarity. The presence of secondary brain abscesses are also not infrequent. The combination of the two with apparent cure is of sufficient interest to merit an attempt at evaluation of therapy. The pulmonary picture (x-ray) presented the following problems in differential diagnosis: tumor, tuberculosis, subphrenic abscess, and echinoccus cyst. The definite etiological factors for both the cerebral and pulmonary lesions were not obvious until the contents of the brain abscess were cultured and revealed Actinomyces bovis.

If the spinal fluid had been cultured for fungi it would most likely have revealed the actinomyces. The exact etiological relationship between the pleuro-pulmonary lesions and the brain abscess could not be established because adequate material was not accessible by chest tap, and bronchoscopy was refused. Actinomycotic pleurisy and empyema have been observed. In the lungs the fungi form abscesses which break down into small rather than large cavities. Contrary to the generally accepted opinion, thoracic lesions are usually of endogenous origin. Actinomyces occur in salivary calculi or tartar, and detached masses of this material may be aspirated. Aspiration of straw or pieces of leather by accident is a questionable source of these organisms for chest lesions.

The chemotherapy which this patient received was ineffectual alone until the abscess was evacuated. This drainage allowed for a reduction in the vascular stasis and edema and thus enabled the chemotherapeutic drugs to penetrate the zone of involvement. This reasoning applies to abscesses in general. The advent of chemotherapy has reduced the moridity and mortality which was so high when drainage alone was our only means of treating the brain abscess regardless of the causative agent. The cure of so virulent an infection of the brain as is usually produced by actinomyces indicates the remarkable action of sulfadiazine and penicillin.

## CONCLUSION

1. A case of actinomycotic abscess of the brain, most likely associated with pleuro-pulmonary lesions of the same etiology is reported.
2. Anti-microbial therapy followed by surgical drainage resulted in cure.
3. The importance of culturing spinal fluid for fungi is stressed by this experience.

# Appendiceal Abscess in a Four Month Old Infant

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Inflammation of the appendix in early infancy occurs often enough to deserve greater consideration as a diagnostic possibility. The early literature of appendicitis in infancy reveals that the diagnosis was usually made postmortem rather than at operation. The sequence of events to be reviewed in the clinical picture of a four month old infant followed the course usually seen in older children and adults.

A brief review of the literature reveals that appendicitis in the male outnumbers the occurrence in the female infant because of the frequency with which the appendix is found in inguinal hernial sacs. In most cases of true intra-abdominal appendicitis in infants, gangrene and early rupture is rapidly followed by generalized peritonitis and death. Localization and walling off in the abdomen is uncommon.

All unoperated infants under four weeks of age have died. The prognosis in hernial appendicitis is better. Four cases of pre-natal appendicitis were reported by Jackson[1], Hill and Mason[2], Corcoran[3] and Kummell. All died by the third day of life.

Wilson[4] includes these pre-natal cases and a critical analysis of appendicitis in infancy along with his case report of a three and one half pound premature infant with appendicitis at sixteen days of age. This infant showed symptoms of abdominal pathology on the fourteenth day, and at operation two days later revealed acute appendicitis with diffuse peritonitis. The patient died forty-eight hours later. Four other cases of intra-abdominal acute appendicitis, as distinguished from those found in umbilical and scrotal hernial sacs, have been met with in infants five, fourteen, sixteen and twenty-one days old. Of these thirty-seven were under one year. Reports by several authors on 2,988 cases revealed six one year olds or under. Holman[6] reported no child under two years of age in 1,200 cases. Marinan[7] cited a case of perforative appendicitis complicating acute nephritis in a five month old infant.

Coleman[8] mentions a five month old infant with acute appendicitis that resembled an intussusception. Ham[9] described appendicitis in a twelve day old infant, but the pathology was present within the contents of a scrotal hernia. Pope's[10] three weeks old infant had a five day history of swelling and inflammation of the penis and scrotum. This was treated with incision and drainage at which site a sinus formed which was followed by a hernia. Two years later in doing a herniotomy it was found that the appendix was adherent to the sinus and showed evidence of old inflammation.

In Wilson's review (with an excellent bibliography[1-28]) he tells of thirty-two cases of acute appendicitis in infants four to thirty-two weeks of age taken from the literature. Six were present in hernial sacs and twenty-six were true abdominal cases. In twenty-nine patients, where the sex was designated, twenty-three were males and six females. The outcome was mentioned in twenty-seven instances, the results being fourteen recoveries and thirteen deaths. Under the age of four weeks there were fifteen cases cited. Six of these were in hernial sacs and all of these patients recovered. The remaining nine were true intra-abdominal appendicitis and all proved fatal. In twelve of these cases the sex was mentioned, and they were divided into eight males and four females.

P. M., four month old negro female infant, entered the Cook County Children's Hospital, Nov. 5, 1948. She had been in good health until Oct. 26, 1948. Four hours after having partaken of potatoes and milk, she awoke and gagged. Vomiting occurred several times during the night and irritability was associated with anorexia. When brought to the hospital for examination these symptoms were attributed to an upper res-

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piratory infection with constipation since there had been no bowel movement for forty-eight hours. Seen again on Oct. 29, 1948 because of continued abdominal pain, fever, anorexia and constipation, the admitting physician sent the patient home again with orders for an enema and symptomatic treatment. Abdominal pain continued for two days and the infant refused to play. Anorexia was marked but vomiting had ceased. The day before admission, nine days after the onset, the infant became drowsy and cried severely at intervals. Fever was marked but no vomiting occurred. The stools were described as "lumpy".

At the third examination in the admitting room, the infant who had now been ill for ten days, was found to have a temperature of 105 degrees, respiration 34, and pulse 130. The respirations were short and rapid and abdomen was distended, tense and very painful to palpation. A very tender grapefruit sized mass was palpable in the right lower quadrant. The legs were flexed on the abdomen. Peristaltic sounds were good. The blood count revealed Hemoglobin 70%, red blood corpuscles 3,850,000, white blood cells 29,800 with 83% polymorphonuclears. The following day the white blood count was 36,100 with 89% polymorphonuclears. Table I.

The case seemed to be one of appendiceal abscess but the extreme rarity of a walled off mass in such a young patient required the following conditions to be ruled out: 1) Wilm's tumor, 2) Neuroblastoma, 3) Mesenteric Cyst, 4) Enterogenous Cyst, 5) Dermoid Cyst.

The findings remained localized to the right lower quadrant with no sign of generalized peritonitis. Vomiting never recurred nor was there any evidence of diarrhea, constipation, or intestinal obstruction. A flat x-ray plate of the abdomen showed the right sided mass with the bowel pushed to the left. A barium enema filled to the transverse colon, then the contrast material went down, then up where it entered the small bowel. In the lateral view, it was seen that the descending colon was pushed forward and ascending colon upward and backward. This view also showed a typical "step-ladder" picture identified with intestinal obstruction, but no signs of obstruction ever appeared. See Figures 1, 2 and 3.

The intravenous pyelogram, Roentgen study of the chest, Mantoux 1-1000 and the Wassermann test were all negative. Culture of aural discharge on Nov. 26 was positive for E. Coli. Urine culture on Nov. 29 revealed E. Coli and pseudomonas aerogenes. Culture from the abdominal abscess was positive for E. Coli and pseudomonas aerogenes.

Ten days after admission umbrathor was given by mouth and the x-ray department reported, "the only conclusions one can derive from the examination is that we are dealing with a large, soft tissue mass which in a child of this age causes one to consider Wilm's tumor and sympathico-blastoma."

The diagnosis having been narrowed down to that of appendiceal abscess, which was apparently well walled off and localized, conservative management as employed in older children and adults was considered to be the treatment of choice. This attitude was concurred in by the surgical department and the treatment consisted of intravenous fluids, blood transfusions, penicillin 50,000 units every three hours by injection, streptomycin one gram a day, sulfasuxidine and adequate multiple vitamins.

The infant showed only moderate toxemia, no vomiting, and distress was evident only on abdominal palpation. Anorexia persisted, the temperature subsided gradually, but never re-

Table I

BLOOD COUNTS

| Date | Hb | R.B.C. | W.B.C. | Polys. | Eos. | Lymph. | Mono. |
|---|---|---|---|---|---|---|---|
| 11- 6-48 | 60 | 3,330,000 | 36,100 | 89 | | 8 | 3 |
| 11-10-48 | 70 | 4,880,000 | 23,700 | 75 | | 17 | 7 |
| 11-19-48 | 70 | 3,990,000 | 28,500 | 71 | | 15 | 13 |
| 11-23-48 | 63 | 3,960,000 | 27,250 | 54 | | 43 | 2 |
| 11-27-48 | | | 23,200 | 66 | | 29 | 3 |
| 11-30-48 | | | 17,300 | 63 | | 35 | 1 |
| 12- 4-48 | 60 | 3,180,000 | 19,900 | 58 | 11 | 30 | 1 |
| 12- 9-48 | | | 22,100 | | | | |
| 12-15-48 | 70 | 4,140,000 | 22,900 | 25 | 3 | 62 | 10 |
| 12-21-48 | 72 | 4,190,000 | 13,000 | 38 | 4 | 47 | 10 |



Figure 1



Figure 2



Figure 3

mained normal. The white blood count and polymorphonuclear preponderance decreased moderately, but the size of the mass remained constant.

Because of the persistence in the size of the swelling, anorexia and failure to gain weight, surgical intervention was carried out on Dec. 1, 1948, twenty-five days after admission and five weeks after the onset.

A right sided large walled off peritoneal abscess with necrotic material and brownish-creamy pus was discovered in the retro-cecal area. An incision was made by Dr. Carl Davis Jr., and several ounces of pus removed. Culture of this material revealed E. Coli and pseudomonas aerogenes. A drain was inserted and Wangensteen suction employed for two days. The temperature subsided immediately, white count returned to normal, appetite was restored, and the infant was cheerful. Drainage continued for a few weeks when the wound closed and the patient was discharged.

April 24, 1949, the infant was re-examined. No mass was palpable, the patient was afebrile, and the blood count was completely normal. Two days later surgery was reinstituted to remove the "blown out" appendix. Dr. Egbert H. Fell reported the surgical findings as follows: 1. An omental inclusion cyst, the residuum of appendiceal abscess containing mucus, a fecalith and the tip of the appendix. This was adherent to the right lower quadrant wound. 2. Eight cm. proximal to the ileo-cecal valve were six black sero muscular stitches. 3. Umbilical hernia. 4. No evidence of base of appendix. Cecal area covered with Jackson's membrane.

The surgery consisted of: a) Excision of old right rectus scar. Delineation of fascia and muscle layers. b) Delivery of omental cyst by clamping, cutting and tying its superior and lateral attachment.

Recovery was uneventful and the patient was discharged.

## COMMENT

The inadequacy of the omentum which is short and transparent in a four month old infant, the poor blood supply to the appendix, the thinness of its walls and the meager general immunity at this age make the clinical course in this case quite unusual. In older children and adults the protective power of the abdominal peritoneum in walling off an abscess produced by a ruptured appendix is not an unexpected occurrence. Appendicitis in the very young is relatively rare because the cone-shaped lumen of the appendix permits free drainage into the cecum.

The occurrence of appendicitis in young infants is predisposed by the prolapse of the appendix into an inguinal or scrotal hernial sac. This altered position results in impairment of circulation when stasis is present with consequent infection. The good prognosis in these cases is due to surgical intervention for the herniotomy.

Abdominal examination of the crying infant

may be enhanced by the administration of mild sedative for relaxation. Persistent local muscle spasm may be more properly evaluated by this means.

SUMMARY

1. A case of walled off appendiceal abscess in a four month old infant is reported.
2. Conservative management was carried out for five weeks after the onset when incision and drainage became necessary.
3. Five months later surgery revealed the appendix completely sloughed off and part of an omental cyst.
4. The accurate early diagnosis of appendicitis in infants is of utmost importance and will be made more frequently with greater awareness of its occurrence.

30 N. Michigan Ave.

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## PATHOLOGY IMPORTANT IN HYSTERECTOMY

We do not advocate general adoption of total hysterectomy. Individualism is as wise here as in every other surgical procedure. The decision should be made upon a consideration of the pathology involved, the condition of the cervix, the technical problems presented by the individual case and a conscientious self-appraisal by the surgeon of his own capabilities. *Excerpt: Total Versus Subtotal Hysterectomy, E. L. Henderson, M. D., J. Luther Fuller, M. D., Louisville, The Southern Surgeon, May, 1950.*

# Dislocation of the Lumbo-Sacral Spine

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Anterior dislocation of the sacrum from the 5th lumbar vertebral body occurred in the patient whose history is reported. A thorough search of the literature has failed to reveal another reported instance of this condition, though Watson-Jones[1] says, "Displacement identical to spondylolisthesis may be produced acutely by a severe injury in a spine which was previously normal. The pedicles are usually fractured and the 5th lumbar body is dislocated forward. Injury of the sacral nerves may cause saddle anaesthesia of the perineum and paralysis of the sphincters. Reduction may be achieved by the same technic as described for congenital spondylolisthesis."

Miss E. R., age 45, was thrown from a horse at 11 A.M., October 24th, 1945. The horse also fell, landing on the patient's back. The horse's back hit the back of the patient's pelvis. Late that afternoon I saw the woman for the first time in the emergency room of Michael Reese Hospital. She had severe low back pain, pain in the left lower chest, and in the left leg. She could not move either leg and had numbness in both, the left more than the right. Shock was obvious and marked. The right chest wall was very tender antero-laterally. There was deformity of the back with the sacrum seemingly anterior to the vertebral column, and marked tenderness in this area. Neurological examination by Dr. I. Sherman gave the impression of a complete cauda equina lesion from L3 down on the left and SI down on the right. X-rays revealed (1) Fractures of the 6, 7, and 8th right ribs in the mid axillary line in good position, (2) Fractures of the 4th and 5th left transverse processes, (3) A complete dislocation of the lumbar spine with L5 completely posterior to the first sacral vertebra, and overlying of about half the height of the body, with a few small bony fragments, evidently denoting some comminution of the 1st sacral vertebra. (Figure 1.)

The poor general condition of the patient demanded treatment with intravenous fluids and plasma and any attempt at reduction was postponed. The next morning her general condition improved somewhat, and she was then given a general anaesthetic to obtain complete muscular relaxation. She was pulled to the end of the table until the sacrum projected over the edge, each leg being supported by an assistant. Traction was then made against the flexed thighs, and reduction of the dislocation could be felt and heard very promptly. There was complete disappearance of the deformity of the



**Figure 1 — Lateral Roentgenogram before reduction.**

1. Sir Regnald Watson-Jones: Fractures and Joint Injuries. 3rd Ed. Vol. 1, Page 332-1946.

**From the Department of Surgery, Michael Reese Hospital.**



**Figure 2 — Lateral Roentgenogram after reduction.**

back. X-ray examination confirmed the complete reduction of the dislocation. (Figure 2.) The patient was placed on a Stryker frame. Because of inability to void, a retention catheter was inserted into the bladder and tidal drainage was instituted. There was marked paralytic ileus for several days, after which her general condition began to improve.

During the next few weeks there was some improvement in the motor power of some muscles, especially of the right leg. Exploratory laminectomy was done on November 30th, 1945 (Dr. P. Bucy) confirming the complete tear of some of the roots of the cauda equina. Organizing clots and scar tissue which compressed the cauda were removed. Slight improvement in the motor power continued. On December 29th, 1945, the catheter slipped out of the bladder and spontaneous voiding was accomplished, and in several days there was no residual urine. Orthopedic care (Dr. S. Sideman) and physical therapy continued and about February 1, 1946 three months after the injury, a long left leg and a short right leg brace were applied, and the patient began to be up and about some on crutches.

On June 25th, 1946, neurological examination by Dr. Sherman revealed marked atrophy of the left leg, somewhat less of the right. The right patellar reflex was brisk, the left absent. Motion of the right leg was good above the knee. The tibialis anticus was fairly good, the posterior tibial fair, the extensor hallucis longus and the extensors of the toes were weakly present, as were the plantar flexors of the toes and the peroneal muscles. Other muscles had no motion. The left leg had motion only in the thigh muscles. There has been little change in the neurological picture since, and the patient is ambulant with the aid of braces and a cane.

## SUMMARY

A report is made of an anterior dislocation of the sacrum off the lumbar spine with cauda equina injury. The dislocation was reduced, but much of the motor paralysis of the lower extremities has been permanent.

104 S. Michigan Ave.

# Idiopathic Thrombocytopenic Purpura
## Associated with Accessory Spleens and Complicated by Severe Hemothorax and Hemoperitoneum

**George C. Coe, M.D., Joseph T. Gault, M.D., and Hyman J. Hirshfield, M.D.**
**Chicago**

Primary or idiopathic (thromboeytopenie) purpura hemorrhagiea ean no longer be eonsidered a rare entity and the criteria for aecurate diagnosis are well established: repeated erops of purpura, often post-traumatie, spontaneous hemorrhages from the mucous membranes, marked and unaecountable reduetion in blood platelets, prolonged bleeding time, deereased elot retraetion, normal clotting time and inereased capillary fragility. In doubtful eases bone marrow study is generally diagnostic. Nevertheless, such cases go unrecognized until serious and sometimes fatal hemorrhage results. This is partieularly true in young women because it is not generally appreeiated that vaginal bleeding may be the major symptom and occasionally the only symptom of purpura. In a recent article Walsh and Donlon[1] make an urgent plea for the early recognition of purpura hemorrhagica as the cause of fatal menorrhagia in young women and report two sueh cases. Nor is it realized that, although uneommon, purpura hemorrhagiea may be the eause of hemothorax and hemoperitoneum. This lack of appreciation is partly attributable to the fact that most text-books of medicine make only passing reference to the possible etiologie role of blood dyscrasias in considering the differential diagnosis of bleeding into the serous cavities of the body. The ease we are herein reporting dramatically demonstrates the above facts.

The patient, Miss D. G., aged 17 years, was first seen by a gyneeologist because of eontinuous vaginal bleeding of four weeks' duration. Recognizing that the menorrhagia was not due to pelvic pathology, he referred her for medieal care. On admission to the hospital (July 7, 1947) examination revealed small purpuric lesions about the lower lip and palate and fading ecchymoses about the left hip and leg (attributed to trauma by the patient). Vaginal bleeding was marked and persistent and pyorrhea alveolaris was noted with bleeding from the gums. All other physical findings were negative. Laboratory studies showed the following: hemoglobin 39.6 per eent, erythrocytes 2,690,000 and white cells 5,800 with 79 per cent polys, 15 per cent lymphocytes and 3 per eent monoeytes; platelet count 27,000 (control 270,000); eoagulation time 5½ minutes and bleeding time in excess of 15 minutes; blood vitamin C level 1.55 mgm.; prothrombin time 100 per eent of normal and negative serology. Three days later the platelet eount was 20,000 and hemoglobin dropped to 33 per cent with 1,870,000 erythrocytes.

Conservative therapy was instituted immediately with multiple blood transfusions, rutin, ete., but the bleeding eontinued unabated. Bone marrow examination shortly after admission showed a small number of megakaryoeytes, abundant elements of both myeloid and erythroid eells with diminution of mature granulocytes (maturation arrest). There was no increase in myeloblasts and erythroid elements were hyperplastie. The erythrocytes showed marked macroeytosis and polychromatophilia and eosinophilie retieulocytes were not increased. Blood culture was negative. Finally, after eleven transfusions, spleneetomy was recommended.

The platelet count before spleneetomy (July 19, 1947) was 36,000 and an additional bone marrow study just before surgery showed only one island of tissue in which megakaryoeytes were quite numerous and eosinophils were not inereased. At operation (J.T.G.) the abdominal eavity, which was entered through a left sub-

From the Medical and Surgical Services of the Mount Sinai Hospital and The Chicago Medical School, Chicago, Illinois.

costal incision, was found to be filled with a thick bloody fluid, 1500 cc. of which was aspirated before any organ could be recognized. The spleen appeared to be of normal size and was removed by the usual procedure. It was noted that the active oozing from the serous surfaces and the wound margins stopped almost immediately after ligation of the splenic vessels. A thorough search for accessory spleens was then made in the order suggested by Curtis and Movitz[2]. One large mass with the shape, color and consistency of a spleen was found in the pedicle and two smaller masses, one in the transverse mesocolon and the other in the omentum, were also excised.

Examination of the excised specimens (Dr. I. Davidsohn, Pathologist) revealed the following: The spleen (12.5 x 7 x 3 cm.) weighed 140 grams; the larger mass measured 2 x 5 x 0.5 cm. and the two smaller masses measured 3 mm. in diameter. The larger mass was found histologically to have the typical structure of a spleen while the smaller masses were hemolymph nodes. The pathologic diagnosis for the spleen and accessory spleen was hyperplastic splenitis and for the hemolymph nodes, hyperplastic lymphadenitis.

The platelet count two hours after splenectomy was 46,000 and daily counts thereafter showed a progressive increase up to 349,000 on the sixth postoperative day, followed by a progressive decline to 92,000 on the day of discharge, fifteen days after the operation. All bleeding manifestations stopped within several days but a low grade fever persisted; this was attributed to absorption of blood from the abdominal cavity. All told, she had received, pre-during and postoperatively, fourteen whole blood transfusions and two units of packed cells equivalent to 1000 cc. of whole blood.

She was rehospitalized within 48 hours after discharge because of pain in the left chest, dyspnea and a fever of 103.8 orally. Examination revealed a left sided pleural effusion with findings indicative of pneumonic infection. Thoracentesis was done and 2000 cc. of blood was removed. A blood count at this time showed hemoglobin 77.4 per cent, red cells 4,170,000 and white cells 10,000 with a normal differential; platelets numbered 229,000.

Because of the intercurrent infection, both penicillin and sulfonamide therapy were started. Within several days the platelets dropped to 30,000 and bleeding from the gums was noted; they then dropped to 16,000 with only a slight decrease in hemoglobin and red cells. The white count dropped to 5,400 with 57 per cent polys, 24 per cent lymphocytes and 12 per cent monocytes. The coagulation time was 4 minutes, bleeding time was again prolonged beyond 15 minutes and there was no clot retraction in 24 hours. Bone marrow examination showed a decrease in megakaryocytes with hyperplasia of the myeloid and erythroid cells.

Diagnostically, we could not determine whether this recurrence was due to the sulfonamide therapy (secondary purpura), to the presence of additional overlooked accessory spleens, to the toxicity of the pneumonic infection or simply to the fact that the splenectomy had been ineffective. Antibiotic and chemotherapy were immediately stopped and transfusions were again utilized. The platelets gradually rose to 50,000 and all bleeding stopped. The chest cleared up, she became afebrile, the platelets rose to 200,000 and she was again discharged. She has been followed as an outpatient and the platelets gradually and progressively increased to a peak of 498,000. In the fall of 1948 the count was 435,000 and in the Spring (March, 1949) it was 315,000; the last blood count showed hemoglobin 84 per cent, red cells 4,446,000 and white cells 8,700 with a normal differential.

Discussion: According to the criteria set forth by Schwartz[3], the bone marrow studies eliminated the possibility of any allergic factor being etiologically responsible for the intense purpura. The diminution of megakaryocytes, except for one island of tissue in the second bone marrow examination, indicated a poor prognosis. Nevertheless, in order to avoid fatal hemorrhage, emergency splenectomy had to be done. The patient's age was in her favor for it has been shown that splenectomy is about twice as effective in the earlier decades of life than in the later ones[4]. It is now about twenty months since the splenectomy was done and we feel certain that the cure will be permanent although we are cognizant of the data published by Elliott[4] who reports fatal recurrences as late as two years after splenectomy. Finally, we want to emphasize strongly that careful search must be made for accessory spleens if the operation is to be effective. Curtis and Movitz[2] report the

frequency of accessory spleens at necropsies at about 10 o 35 per cent and at operations on patients with splenic disease at 20 to 40 per cent. Common sites for accessory spleens are the hilus, pedicle, omentum, retroperitoneum, splenocolic ligament, mesentery and the left adnexa in females.

CONCLUSIONS

We are herein reporting a case of idiopathic thrombocytopenic purpura associated with an accessory spleen in a young woman in whom menorrhagia was the major symptom, complicated by extensive hemothorax and hemoperitoneum and in whom splenectomy was resorted to as a life saving measure despite diminution of megakaryocytes in the bone marrow. Following recovery, a secondary purpura developed with thrombocytopenia due to inadvertently instituting chemotherapy for a pneumonic infection superimposed on a compressed lung due to the extensive hemothorax. Several pertinent facts are worthy of re-emphasis: menorrhagia in a young woman should suggest a blood dyscrasia in the absence of pelvic pathology or pregnancy; hemothorax and hemoperitoneum may be caused by purpura or other blood dyscrasias associated with hemorrhagic manifestations; despite bone marrow findings, splenectomy may be a life-saving operation when all conservative measures fail to stop the bleeding; and careful search must be made for accessory spleens.

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## TREATMENT OF ALCOHOLISM

Preliminary studies on the effects of antabus (tetraethylthiuram disulfide) in the therapy of alcoholic patients indicate that it is very valuable in providing a "chemical foundation" for sobriety, even in those with a severe, long term drinking problem. In the first thirty patients treated, a favorable degree of control of the alcoholism has been effected in approximately 80 per cent. When taken regularly the drug maintains in the patient a very high degree of sensitivity to alcohol, quickly producing a number of very distressing bodily reactions whenever even very small amounts of spirits are ingested. Because of its potential dangers, antabus should be used only after thorough clinical and laboratory studies in properly staffed institutions. It is contraindicated in individuals with existing major phychosis or drug addiction and must be used only with caution in patients with diabetes mellitus, cardiovascular disease, goiter, pregnancy, epilepsy, asthma, and hepatic disease. Antabus therapy should be considered only one aspect of the total treatment program for the alcoholic patient. *Excerpt: The Use of Antabus in the Therapy of Alcoholic Patients, John D. Moriarty, M.D., Los Angeles, California Medicine, August, 1950.*

# NEWS OF THE STATE



## CHAMPAIGN

**Outstanding General Practitioner.**—Dr. W. E. Schowengerdt, Champaign, recently was elected "the outstanding general practitioner" of 1950 in Champaign County. This makes him eligible as a candidate as the outstanding Illinois practitioner. Dr. Schowengerdt was a member of the Champaign school board for thirty-four years when he resigned in 1947.

## COOK

**Society News.**—The Chicago Diabetes Association was addressed at Thorne Hall, October 6, by Drs. Ralph A. Reis and M. David Allweiss, both of Northwestern University Medical School, on "Management of the Pregnancy, the Diabetes, and the Newborn, in Pregnancy Complicated by Diabetes." Dr. Arthur R. Colwell, also of Northwestern, discussed "Management of Diabetes in Children."—Dr. Philip Thorek discussed "Carcinoma of the Esophagus" and "Gallbladder Disease" before the Texas Academy of General Practice in Fort Worth, Texas, September 25. "Pre and Postoperative Care in the Cancer Patient" was the title of Dr. Thorek's presentation, September 28, at the Savanna Tumor Diagnostic Clinic in Savanna, Illinois.

The Chicago Society of Physical Medicine and Rehabilitation held a meeting October 25, at 8 p.m., at the University of Illinois College of Medicine with Dr. H. Worley Kendell who presented "Electromyography in Physical Medicine and Rehabilitation." Other speakers in the future will be Dr. Charles O. Molander, November 22; Arthur H. Steinhaus, Ph.D., January 24; Dr. Disraeli Kobak, February 28; Dr. Harold Sofield, March 28; Dr. Louis B. Newman, April 25; and Dr. Frank H. Krusen, Rochester, Minnesota, May 23. Dr. Arthur A. Rodriquez is secretary-treasurer of the society and Dr. Louis B. Newman, president.

**Personal.**—Dr. Mark H. Lepper has been appointed to the faculty of the College of Medicine as an associate professor in the department of preventive medicine by the University of Illinois Board of Trustees. Dr. Lepper has done research work in the therapies of infectious diseases, toxic reactions to drugs, particularly drug allergy, and inhibition and antigen antibody reactions.

**Changes in Faculty.**—Appointments at the Chicago Medical School include Drs. Harry B. Lerner, Daniel L. Streicher, Herbert H. Krantz and Harold R. Kamenear, assistants in the department of medicine; Dr. Louis Berlin and Bernard Skorodin, associates in neurology in the department of neurology and psychiatry; and Dr. Hyman S. Gordon, assistant in pediatrics, department of pediatrics. Promotions on the faculty include the following: Dr. David Cohen to professor of dermatology, Dr. Donald H. Atlas to associate professor of medicine, Dr. Irving Siegel to associate professor of obstetrics, Dr. Morris Goldenberg to assistant professor of pathology, Dr. Paul H. Kopper to assistant professor of microbiology and public health, Dr. David B. Radner to assistant professor of medicine, Dr. Kurt Stern to assistant professor of pathology and Dr. Meyer J. Steinberg to assistant professor of medicine.

**Blatt Memorial Lecture.**—Dr. John Caffey, clinical professor of pediatrics, Columbia University College of Physicians and Surgeons, New York, gave the second Maurice Lamm Blatt memorial fund lecture at Cook County Hospital, October 9. His subject

was "Infantile Cortical Hyperostosis and Vitamin A Poisoning."

**The Sheinin Lectureship.**—Dr. Robert E. Gross, surgeon in chief of the Boston Children's Hospital, gave the first annual John J. Sheinin lectureship, October 16, on "Heart Diseases." The lectureship was established in honor of Dr. John J. Sheinin, president, Chicago Medical School, by the Beta Tau Chapter, Phi Delta Epsilon.

**Students Honor Instructors.**—Fourth-year students in the University of Illinois College of Medicine have presented Dr. Carroll L. Birch and Dr. Francis L. Lederer with the Raymond B. Allen Instructorship Awards for the 1949-50 school year.

The awards, designed to honor excellency in individual instructorship rendered by faculty members to students, were given to Dr. Birch for didactic instruction and to Dr. Lederer for his clinical teaching.

Dr. Birch also received the award presented by the second-year students.

Third-year students presented their awards to Dr. Philip Thorek for didactic instruction and to Dr. Louis Feldman for clinical instruction. Dr. Otto A. Bessey received the award from first-year students.

Each of the award winners received a key in the form of a golden apple. Their names will be placed on the permanent plaque which hangs in the Chicago Illini Union.

The awards were presented by the Student Council of the College of Medicine.

**Hospital News.**—The Mercy Hospital Internes and Residents Alumni Association held its annual meeting, October 14. The program included scientific presentations, a luncheon and a formal dinner dance.

**Grants for Research.**—The Chicago Medical School has received a grant in the amount of $4,500 from the National Institue of Mental Health through the U. S. Public Health Service. The grant will be used by Dr. George C. Clark, associate professor of neuro-anatomy, for a research study for the determination of the extent of variation in the cell size and arrangement of selected portions of the brain.

**Borden Award.**—Dr. John M. Marshall, Jr., an intern at the University of Illinois Research and Educational Hospitals, has been named the winner of the Borden Undergraduate Research Award for 1950 by the University of Illinois College of Medicine.

The award represents a gift of $500. Originality and thoroughness of research are of primary consideration in selecting the winner of the award, which is given by the Borden Company Foundation, Inc.

Dr. Marshall received the award for his investigation of the role of the enzyme, renin, in high blood pressure produced in animals by constriction of the arteries to kidneys.

**Travel Award Goes to Dr. Schiller.**—Dr. Alfred A. Schiller, assistant professor of physiology, University of Illinois College of Medicine, was the recipient of a travel award from the Federation of American Societies for Experimental Biology which Dr. Schiller made possible with his presentation of a paper on "Effects of a Vitamin P Flavanoid and Ascorbic Acid on the Cutaneous Circulation Determined by a New Quantitative Method." The paper was delivered before the 18th International Physiological Congress at Copenhagen, Denmark, in August. The $500 award is one of five made by the Federation to scientists under thirty-five years of age who submitted the best contributions in physiology and gave the best evidence of creative productivity.

## DE WITT

**Kenney's Only Physician Retires.**—Dr. Fred M. Blome, Kenney, has announced his retirement from the active practice of medicine where he has been practicing for many years. He and his wife plan to live on their farm in Sheridan, Michigan. He is the only physician in Kenney.

## JO DAVIESS

**Society News.**—The Jo Daviess County Medical Society held a dinner meeting, September 21, in Galena, honoring Drs. C. G. Buford and U. S. Lewis as members of the Fifty Year Club of the Illinois State Medical Society, with Dr. J. S. Lundholm, Councilor of the First District, presiding.

## MACON

**Society News.**—The Macon County Medical Society held a meeting, September 26, at the St. Nicholas Hotel with the following speakers: Dr. William B. Wartman, Chicago, "Recent Advances in Cardio-Vascular Diseases (Arterial Occlusion and Infection)" and Mr. Charles H. Meredith, Quincy, on "A Report on the Illinois Healing Arts Committee."

## MADISON

**Society News.**—Dr. Robert J. Mueller, instructor in neuropsychiatry, Washington University School of Medicine, St. Louis, addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, September 7, on "Psychosomatic Medicine."

## MORGAN

**Society News.**—"Pulmonary Insufficiency" was discussed by Dr. Emmett Pearson, Springfield, before the Morgan County Medical Society, October 12.

## ROCK ISLAND

**Society News.**—Dr. Walter Carroll, assistant professor of surgery, Northwestern University Medical School, addressed the Rock Island County Medical Society at St. Anthony's Hospital, October 10, on "Carcinoma of the Breast." The society was addressed, September 12, at the Moline State Hospital,

by Dr. Marcus Emmons, Clinton, Iowa, on "A Discussion of Common Problems in Psychoneurosis."

## UNION

**Dr. Nobles Retires.**—Dr. Charles D. Nobles, seventy year old superintendent of Anna State Hospital, will retire December 31, it is reported. Dr. Nobles has worked for the Illinois Department of Public Welfare since 1923, serving as superintendent of the Anna State Hospital since 1944.

## VERMILION

**Society News.**—At a joint meeting of the medical and dental societies of Vermilion County and representatives of various industries and other community activities, October 3, Dr. R. Haynes Barr, Owensboro, Kentucky, spoke on "The Question of Socialization of Medicine."

## WARREN

**Dr. Graham Honored.**—Dr. Ralph Graham was honored September 7 at a dinner given by the Warren County Medical Society to mark his induction into the Fifty Year Club of the Illinois State Medical Society. Dr. John Bohan, Alexis, president of the county medical society, presided. The presentation of the insignia of the Fifty Year Club was made by Dr. Andy Hall, Mount Vernon, recently chosen Outstanding General Practitioner by the American Medical Association, who is head of the Fifty Year Club. Among the speakers who paid tribute to Dr. Graham for many years of service were Dr. Harold M. Camp, Monmouth, Secretary of the Illinois State Medical Society; Dr. Harry M. Hedge, Chicago, President, Dr. Charles P. Blair, Monmouth, Chairman of the Council, and Dr. Edwin M. Miller and Dr. Harry A. Oberhelman, both of Chicago. The principal speaker was Dr. Ernest E. Irons, Chicago, the immediate past president of the American Medical Association. Other talks were made by Mayor Ralph Wells, Monmouth, and Dr. James Harper Grier, president, Monmouth College Club. Dr. Graham graduated at Rush Medical College in 1900.

## WINNEBAGO

**Society News.**—Dr. Stanley W. Olson, dean, University of Illinois College of Medicine, spoke before the Winnebago County Medical Society, October 3, on "Individual Responsibility in Community Care of Chronic Disease." The county medical society was the guest of Dr. and Mrs. Carl Hamann at a picnic luncheon at Elmlawn on September 29.

## GENERAL

**Welfare Department Statistics.**—The book population of all institutions July 31, 1950, was 55,389. This includes not only those present but also all those in out-patient convalescent care. The resident population July 31, 1950 was 48,281. This figure does not include pupils at schools for Deaf and Blind, who were home for summer vacation.

The greatest increase over July of last year was in the nine hospitals for the mentally ill, in which the population rose 843. During the month there were 1,074 admissions, 688 discharges and 244 deaths. Three-hundred forty-seven were released on conditional discharge and 43 were placed in family care. There were 39,571 on books July 31, 1950.

The two institutions for the mentally defective (Dixon State Hospital and Lincoln State School and Colony) show an increase of 238 over previous year. The resident population was 9,525 with 10,659 on books July 31, 1950.

There were 368 in Security Hospital July 31, 1950. Of this number, 281 were mentally ill and 87 were mentally deficient.

At Neuropsychiatric Institute, where most admissions are temporary for special treatment, 55 patients were present at end of month.

The Veteran's Rehabilitation Center, Chicago, and the Veterans' Clinics, Champaign, Rockford, and Peoria, received 76 new cases during the month. There were 1,336 visits to the clinic in Chicago, 180 in Champaign, 12 in Peoria, and 26 at Rockford. Since opening the centers, 6,493 veterans have received treatment at Chicago, 262 at Champaign, 43 at Peoria and 93 at Rockford.

The Division of Veterans' Service reported 3,254 present in all Welfare institutions July 31, 1950. Of this number, 1,794 were World War I veterans and 863 were World War II veterans. There were 217 admissions, 144 discharges and 16 deaths during the month.

The Chicago Community Clinic reported 454 new patients and 45 former patients during the month. Of the number, 428 of the new patients were former patients in state hospitals and all of the former patients interviewed were previously confined in state hospitals.

In addition, 1,364 patients were interviewed in out-patient psychiatric clinics. There were 2,732 visits to these clinics during the month of July.

Boys' Training School, Girls' Training School, Women's Reformatory, and Illinois State Reformatory, reported 898 juvenile delinquents, felons, and misdemeanants present July 31, 1950. Forty-six were received from court and 51 were discharged during the month.

There were 402 pupils present at Children's Hospital-School and Soldiers' & Sailors' Children's School. The Schools for Blind and Deaf were closed for summer vacation.

There were 1,222 present at Soldiers' & Sailors' Home and 92 at Soldiers' Widows' Home.

The Institute for Juvenile Research interviewed 166 new cases during the month. There were 111 case reports during the month and 45 educational activities.

Clinical and diagnostic services for Eye and Ear Infirmary administered 15,330 treatments during the month of July, while Clinics for Trachoma Control and Prevention of Blindness administered 856 treatments during the month.

## DEATHS

ALBERT H. CARTER, Oak Park, who graduated at Northwestern University Medical School in 1906, died October 8, aged 66. He was captain in the medical corps in World War I.

WALTER I. CAROLUS, Sterling, who graduated at The Hahnemann Medical College and Hospital in 1902, died September 18, aged 77. He was a member of the Illinois State Medical Society "Fifty Year Club."

FARIS F. CHESLEY, Chicago, who graduated at Rush Medical College in 1922, died September 12, aged 52. He was assistant professor of medicine at Northwestern University Medical School.

MAURICE DORNE, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died September 24, aged 57. He was an associate in dermatology at Northwestern University Medical School.

EPHRAIM K. FINDLAY, Chicago, who graduated at the University of Manitoba Faculty of Medicine, Winnipeg, Canada, in 1893, died September 27, aged 80. He was senior ophthalmologist at St. Luke's Hospital since 1924.

CLARENCE A. FORTIER, Kewanee, who graduated at Loyola University School of Medicine in 1922, died in St. John's Hospital, Springfield, September 19, aged 54.

WILLIAM F. GRAYSON, Granite City, who graduated at St. Louis College of Physicians and Surgeons in 1898, died September 20, aged 79. He had practiced medicine in Granite City over 50 years.

ARMINA SEARS HILL, Chicago, who graduated at the College of Physicians and Surgeons of Chicago in 1906, died August 22, aged 78. She was affiliated with Women's and Children's Hospital, where she was twice president.

THEOPHIL J. HOLKE, Freeport, who graduated at Washington University School of Medicine, St. Louis, Mo., in 1899, died September 9, aged 74. He was a member of the Illinois State Medical Society "Fifty Year Club."

EMMET KEETING, Chicago, who graduated at Rush Medical College in 1903, died September 16, aged 78. He was a past president of the Northwest Branch of the Chicago Medical Society and the Logan Square Kiwanis Club.

ERIC L. LARSON, retired, Lake Villa, formerly from Chicago, who graduated at Bennett Medical College, Chicago, in 1910, died September 5, aged 71.

PAUL A. ZANDER, Kankakee, who graduated at Ludwig-Maximillians-Universität Medizinische Fakultät, München, Bavaria, in 1908, died September 2, aged 67. He was a staff physician at Kankakee State Hospital for 10 years.

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# "FOR THE COMMON GOOD"

**Health Talk on WGN-TV:**—Since the last Illinois Medical Journal, the following telecasts have been presented over WGN-TV under the auspices of the Educational Committee:

When Your Feet Hurt, Carlo Scuderi, October 25.

The Rh Factor, Israel Davidson, October 2.

Preparing the Surgical Patient, John Scully, Bernard Patrick, George McCurdy, Jean Olson, Ruth Schroeder and Mildred Wickman, October 9. This telecast received the cooperation of V. Mueller and Company and Augustana Hospital in providing extensive equipment.

Ulcers of the Stomach, George Cummins, October 16.

**Your Doctor Speaks over WFJL,** Thursday evenings, at 7:30 carried the following transcribed broadcasts:

George F. O'Brien, October 12, Diseases of Blood Vessels.

Burton C. Kilbourne, October 19, Industrial Accidents.

Louis R. Limarzi, October 26, Your Blood in Health and Disease.

You and Your Baby over Station WAAF, Tuesday mornings at 10:30 a.m., presented the following physicians in live broadcasts:

Franklin Corper, September 26, The Baby at Six Months.

Gustave Weinfeld, October 3, Growth and Development.

Lawrence Breslow, October 10, Enjoy Your Baby.

Maxwell P. Borovsky, October 17, Understanding the Baby.

**Here is Your Doctor over Station WCFL.** Saturday mornings at 11 a.m., presented the following physicians in transcribed broadcasts:

Oscar Becker, October 7, Plastic Surgery.

I. Pat Bronstein, October 14, Your Glands and You.

Samuel Bluefarb, October 21, Common Diseases of the Skin.

Nathan S. Davis, October 28, Understanding Aging.

**Lectures Arranged Through the Educational Committee:**

Harlan English, Danville, Catholic Rural Life Con-

ference, October 16, Status of Medical Service in Rural Illinois.

Eugene L. Slotkowski, Chicago, Mother's Club, Irving Park YMCA, October 24, Keep Your Son Healthy.

James A. Conner, Young Mothers Club of Bryn Mawr Community Church, November 13, My Child Will Not Eat.

Jerome S. Beigler, Oakland Branch Library Forum, November 17, Growing Old Gracefully.

**Lectures Arranged Through the Scientific Service Committee:**

Paul C. Bucy, October 5, Sangamon County Medical Society, Management of Convulsive Disorders.

Elizabeth Painter, Ph.D., Aurora Medical Society, October 5, Physiologic Effects of Radiation.

Hans von Leden, Evanston, November 9, Effingham County Medical Society on Dizziness.

Charles N. Pease, December 14, Effingham County Medical Society on Low Back Pain.

Eugene T. McEnery, December 14, La Salle County Medical Society on Care of the New born.

Wayne W. Flora, Chicago, Iroquois County Medical Society, December 19, on Management of Anal and Rectal Fistula.

**Postgraduate Conference for Bloomington, October 19.**—The Postgradute Education Committee of the Illinois State Medical Society arranged the following conference for the Fifth Councilor District in Bloomington, October 19, with T. C. Scott, Bloomington, vice president of the McLean County Medical Society presiding:

Ralph A. Reis, Toxemias of Pregnancy.

Chester Coggeshall, Diabetes.

I. Pat Bronstein, Pediatric Endocrinology.

In the evening, Mr. John W. Neal spoke on "Voluntary Prepaid Medical Insurance," and Dr. Danely P. Slaughter, on "Recent Advances in Cancer Therapy."

## FIND CHLORAMPHENICOL USEFUL AGAINST BACILLARY DYSENTRY

Good results in treating 35 patients for bacillary dysentery with chloramphenicol are reported by a research group from Washington, D. C.

"Diarrhea usually subsided within three days, and an uneventful recovery ensued in all 35 patients," Drs. Sidney Ross, Frederic G. Burke, E. Clarence Rice and John A. Washington, and Sara Stevens, B. S., all of the Research Foundation, Children's Hospital, say in the August 26 Journal of the American Medical Association.

Although sulfadiazine also is effective against the disease, its usefulness is limited, they point out. Causative microbes frequently become resistant to sulfa drugs, occasional patients are sensitive to sulfa compounds, and administering sulfadiazine to dehydrated patients in the tropical areas where the disease is most prevalent may be hazardous.

Mass case finding in hospitals can be effective if applied to two groups—admissions and personnel. It is known that our medical and nursing personnel are only too often exposed to active cases of unknown tuberculosis. This is especially hazardous in the general hospital since the prophylactic nursing techniques usually fall short of those required in a communicable disease institution. The incidence of tuberculosis among doctors and nurses is already several times that of comparable age groups in the general populations, and they should not be needlessly exposed when the method of detection is so readily available. Hospital Council of Greater New York and New York Tuberc. & Health A.—1950.

With the minimal case of tuberculosis, diagnosis is rarely the clear-cut matter it is in more active, progressive, and advanced cases. It may involve, frequently, the most tedious follow-up and most painstaking analysis and evaluation. These are the lesions, which under normal circumstances, rarely get the doctor's care because of their obscurity and elusiveness—those which may be forever the "silent" lesions in tuberculosis. Robert J. Anderson, M.D., Journal-Lancet, April, 1950.

Every community is entitled to safe water, food, and milk, and protection from unsafe disposal of wastes; to as safe an environment as we know how to provide including pure air; safe streets, homes, places of work, and places of education and recreation; to the best protection we know how to provide from the contagious diseases, including tuberculosis and the venereal diseases; access to good medical care and hospitalization when needed; to the best protection we know how to provide against the special hazards of maternity and infancy; to the best facilities we know how to provide for the healthy development of our children, including correction of crippling physical and mental defects; recognition and treatment of rheumatic fever and other heart disease, and to the knowledge and facilities necessary to prevent as many deaths as possible from cancer, heart disease, diabetes, and the other degenerative diseases. William P. Shepard, M.D., Nat. Tuberc. A. Bull., Oct., 1949.

# appetite must be controlled




"The greatest problem in preventive medicine in the United States today is obesity."[1] And today it is well-known that "*The only way to counteract obesity . . . is by a restriction of food intake.*"[2]

'Dexedrine' Sulfate controls appetite, making it easy for the patient to avoid overeating and thus to lose weight safely without the use (and risk) of such potentially dangerous drugs as thyroid. In weight reduction 'Dexedrine' "*is the drug of choice because of its effectiveness and the low incidence of undesirable side effects.*"[1]
Smith, Kline & French Laboratories • Philadelphia

# Dexedrine* Sulfate tablets • elixir

**A most effective drug for control of appetite in weight reduction**

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.

2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

# A Doctor WHO RAISED HER OWN BABY ON BAKER'S SAYS...

As one who is supposed to know something about infant feeding formulas, and who has actually experienced making them, I have some special comments. With Baker's my baby has had almost no bowel trouble. I find it convenient to keep boiled water and then quickly mix fresh Baker's Milk formula as I need it, so that I never use formula which has been standing around for 24 hours or more. A more complicated formula has to be made at an opportune time and then put away for use. I prefer fresh formula — Baker's Formula.

My baby, Martha, has turned out to be a delightful child and healthier than most. Many new mothers, and fathers too, have asked how I fed her — so I advise Baker's.

Name on request.




Made in Wisconsin from grade A Milk

Baker's Modified Milk is a completely prepared formula for infants, requiring only one simple direction for use—"dilute to prescribed strength with water, previously boiled." In most cases, Baker's can be used from birth to the end of the bottle-feeding period. Write for complete information and samples.

## BAKER'S MODIFIED MILK

THE BAKER LABORATORIES INC.

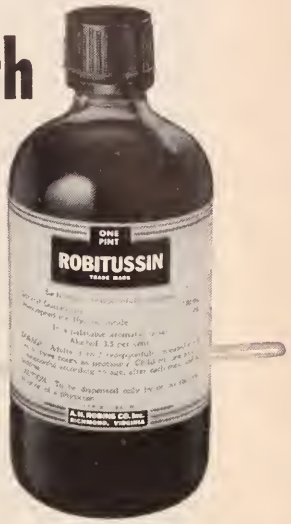
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# NOW, peak performance in non-narcotic COUGH CONTROL with ROBITUSSIN*

**'ROBINS'**




In Robitussin, Robins now makes available a potent new and different therapeutic weapon for the relief of cough. Its major component is glyceryl guaiacolate, shown by recent dependable investigative techniques to be unexcelled for its intense and prolonged action in increasing R.T.F. (respiratory tract fluid).[1,2,3] Also included in the Robitussin formulation is desoxyephedrine—an adrenergic agent to prevent bronchial spasm[5]—which lifts mood and improves patient's sense of well-being.[4] Robitussin's highly palatable aromatic syrup vehicle appeals to young and old alike. Robitussin makes expectoration easier and freer and diminishes dry, irritating cough. It is non-toxic, non-narcotic.

USES Acute colds of head and chest, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, influenza and measles. Helpful as a palliative of harmful cough in tuberculosis, asthma and paranasal sinusitis.

FORMULA Each 5 cc. (1 teaspoonful) of Robitussin contains:

| | |
|---|---|
| Glyceryl guaiacolate | 100 mg. |
| Desoxyephedrine hydrochloride | 1 mg. |

In a palatable aromatic syrup

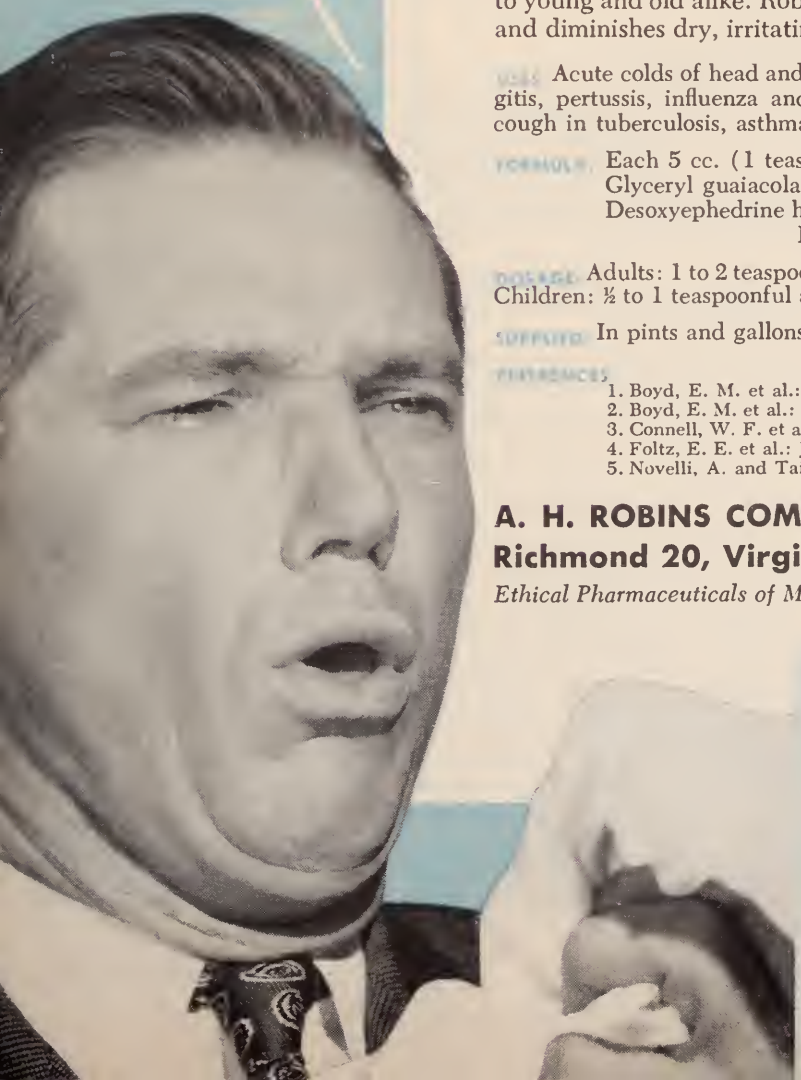
DOSAGE Adults: 1 to 2 teaspoonfuls, repeated every 2 to 3 hours as necessary. Children: ½ to 1 teaspoonful according to age, 3 or more times daily.

SUPPLIED In pints and gallons.

REFERENCES

1. Boyd, E. M. et al.: Canadian J. Res., 23:195, 1945.
2. Boyd, E. M. et al.: Canadian M.A.J., 54:216, 1946.
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4. Foltz, E. E. et al.: J. Lab. & Clin. Med., 28:603, 1943.
5. Novelli, A. and Tainter, M. L.: J. Pharmacol., 77:324, 1943.

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**to facilitate productive cough . . .**
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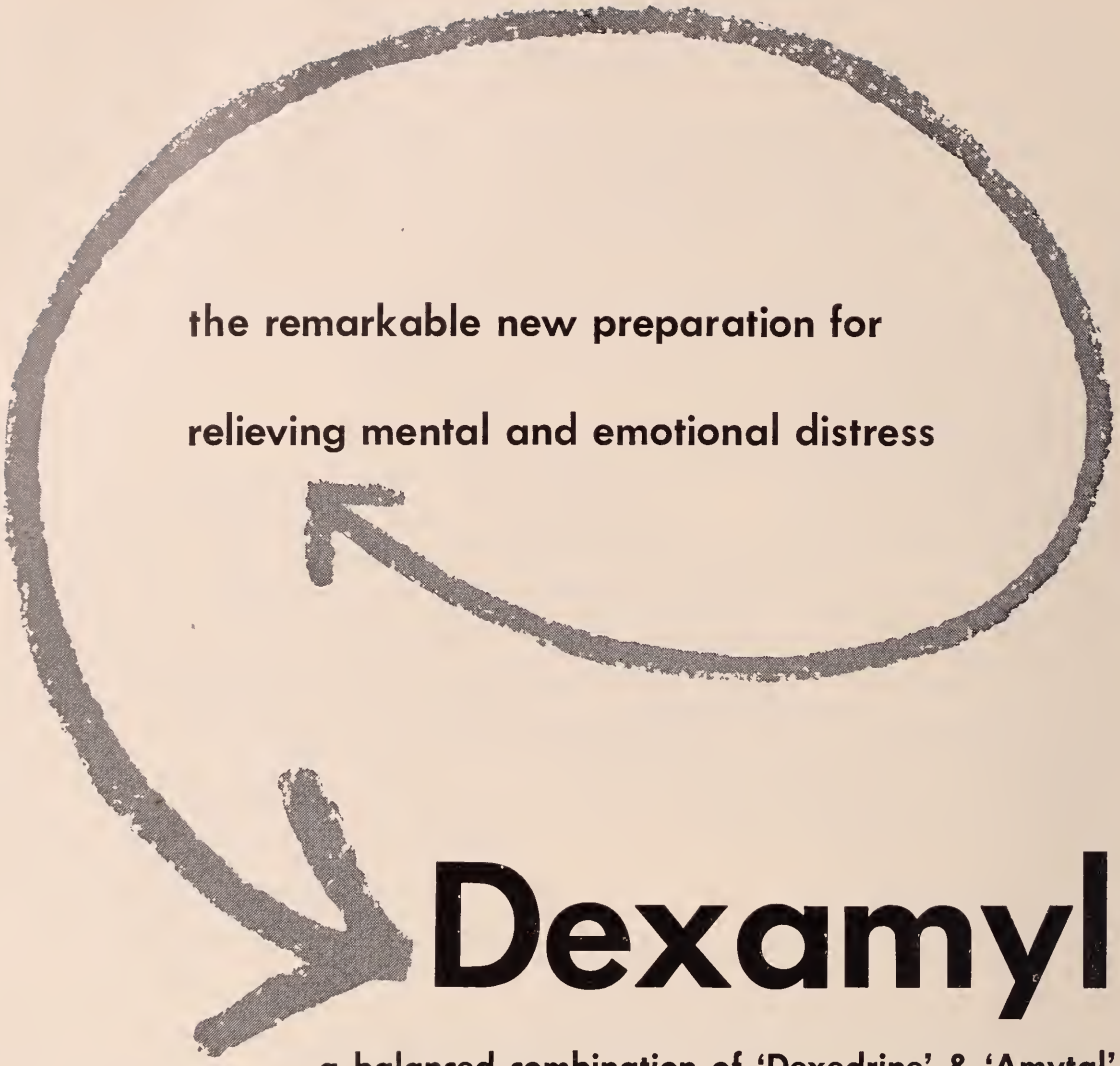

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## *White's* COD LIVER OIL CONCENTRATE TABLETS




A natural source of vitamins A and D in pleasantly-flavored, candy-like form readily taken by children of all ages. Each tablet supplies a vitamin content of 312 units of vitamin D and 3,120 units of vitamin A

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the remarkable new preparation for

relieving mental and emotional distress

# Dexamyl

a balanced combination of 'Dexedrine' & 'Amytal'

In Dexamyl*, the two components—Dexedrine* and Amytal†—work together synergistically to ameliorate mood; to relieve inner tension; and thus to control troublesome symptoms of mental and emotional distress:

The 'Dexedrine', because of its "smooth" and profound antidepressant action, restores mental alertness and optimism and dispels psychogenic fatigue.

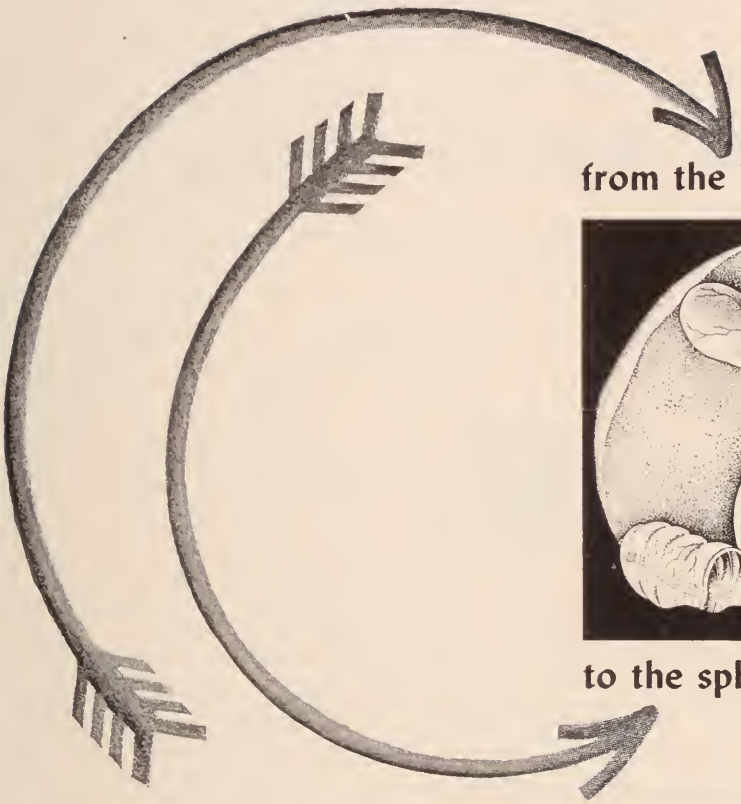
The 'Amytal', because of its calming action, relieves nervous tension, anxiety and agitation.

Widely useful in everyday practice, 'Dexamyl' tablets are available, on prescription only, in bottles of 100 and 1000.

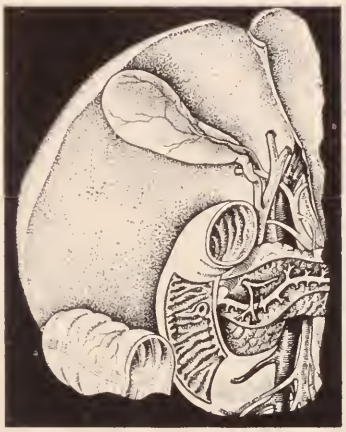
Each tablet contains 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.) 5 mg. and 'Amytal' (Amobarbital, Lilly) ½ grain (32 mg.).

*Trademark, S.K.F. †Trademark, Lilly

**Smith, Kline & French Laboratories, Philadelphia**



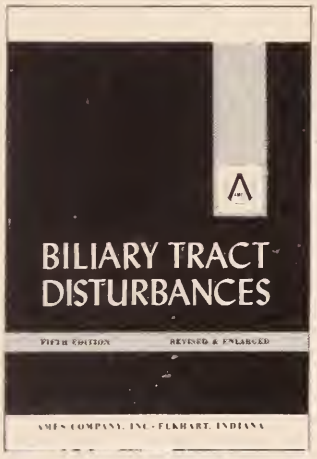
from the liver parenchyma



to the sphincter of Oddi

The area surveyed in the Fifth Edition of "Biliary Tract Disturbances," now available, is the entire, ramified biliary tree—its anatomic and physiologic background and the diagnosis and therapy of its disorders.

Physicians and surgeons acquainted with previous editions of this monograph will find the newly revised, enlarged and illustrated edition even more practical. The brochure concisely presents basic concepts of biliary tract disease, and reviews recent progress in the management of biliary disorders with hydrocholeretics and other measures. You may receive your copy on request from the Medical Department, Ames Company, Inc., Elkhart, Indiana.




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3¾ gr. tablets in bottles of 25, 100, 500, 1000 and 5000.
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3 cc., 5 cc. and 10 cc. ampuls in boxes of 3 and 20.
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# PHYSICAL MEDICINE ABSTRACTS



## DISINTEGRATION OF MOTOR FUNCTION RESULTING FROM CEREBRAL LESIONS

D. Denny-Brown. In THE JOURNAL OF NERVOUS AND MENTAL DISEASE, 112:1:1, July 1950.

Neurologic disorders indicate that, in so far as disorders of sensory, cerebellar and cortical structures bring imperfection to willed movement, each of these structures must contribute to its normal performance. Even though destruction of the precentral gyrus in man has a devastating effect on movement of the limbs of the opposite side, the loss is not absolute. Full understanding of the significance of the motor functions of the cerebral cortex awaits more knowledge of the adequate stimulus for activation of each area.

The behavior of the grasp reflex, instinctive grasping, and the placing reaction indicate that the rolandic cortex is concerned especially with the conditioning of proprioceptive stretch reflexes by contactual effects. The tactile component of this mechanism is not the same as that which perceives touch or pressure, and has tonic, continued, effects as well as special phasic and specific reactions. In the absence of this balance of tactile component in movement the proprioceptive component is overactive and this constitutes spasticity. Lack of integration between perceived and unconscious sensory factors in movement appears to underlie ideomotor apraxia.

Orienting movements of the head, eyes, mouth and limbs are served by extra-rolandic regions of the cortex. Within this system removal of the modulation provided by the cerebral cortex, as in frontal lobe lesions, results in some fixity of the tegmenal mechanism, but in a sense opposite

The rolandic cortex also exerts control over the tegmenal mechanism, but in a sense opposite to that of the extra-rolandic cortex, as shown by the opposite primary movement response to stimulation of these two divisions of cortical motor function after pyramid section. Posture and movement are not separate entities, because all types of movement have the nature of facilitated fragments of postural reactions.

The rolandic and extra-rolandic cortex contribute complementary features to movement. Their interrelationship is such that disorder of one leaves unopposed unwanted activity of the other. Such activity is that which the clinician has habitually called extrapyramidal, but the movements concerned are the result of incoordination between the two systems, and not the special function of one or other. Breakdown of successively lower levels of integration allows the simpler and more powerful antagonisms, total spontaneous activity of one system versus that of the other, leading to athetosis, dystonia and parkinsonian tremor, respectively. These motor disorders like spasticity and rigidity are seen each

(*Continued on page 56*)




While RAYSAL-SUCCINATE contains sufficient salicylic acid for prompt analgesic effect in arthritic and rheumatic patients—it goes beyond the salicylates, since succinic acid is added for therapeutic effect. Succinic acid protects the patient against decrease in blood prothrombin levels and increases the ability of the tissues to utilize oxygen from arterial blood.

The latter action helps eliminate from the tissues those waste products which contribute largely to rheumatic and arthritic pain.

RAYSAL-SUCCINATE is ideally suited as adjuvant treatment to other therapeutic measures employed.

The Safe and Effective Combination for Use in Your Next Case.

*Each "salol" enteric-coated tablet contains:*

Raysal . . . . . 5 grains
(Representing 43% Salicylic Acid and 3% Iodine in Calcium-Sodium Phosphate Buffer Salt Combination)
Succinic Acid . . . . . 2 grains

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## *Raysal-Succinate*

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*OVER A QUARTER CENTURY SERVING THE PHYSICIAN*

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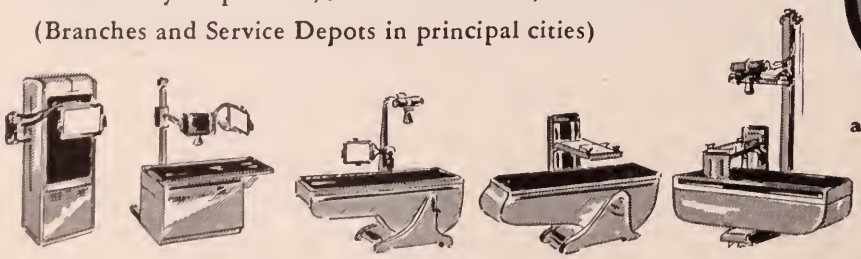
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*"What's best for me in x-ray? What kind, how much?"* The right answer to this question is important... you'll have to live with it... work with it... depend on it. You'd like to keep your x-ray outlay at a minimum: still want to be sure that the equipment you buy can do all the things you'll need to do, now and later.

In short, you're at the point where it would be prudent to call for experienced counsel . . . and your local Picker representative is the man who can offer it to you. He's analyzed and solved dozens of problems like yours. He's primed to *serve* you, not pressured to *sell* you. In your own best interest call in your local Picker man before you come to *any* decision on *any* x-ray apparatus: then judge for yourself.
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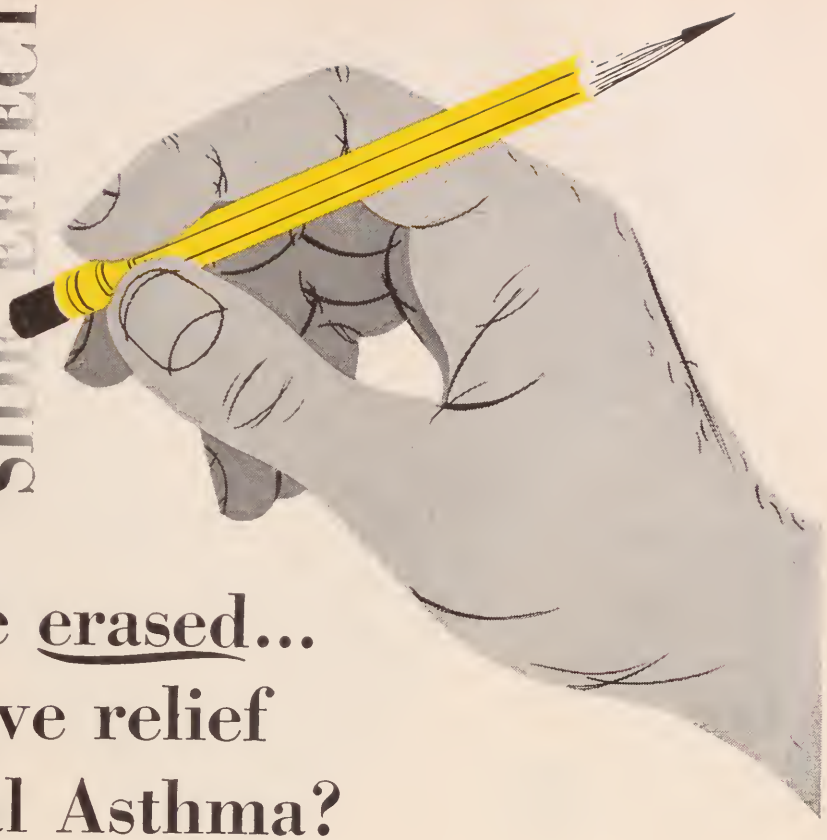
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these are some of the x-ray units in the wide Picker line

SIDE EFFECTS



# Can they be erased... from effective relief in Bronchial Asthma?

Yes, there now *is* a therapy—NETHAPRIN—that gives prompt, symptomatic relief in asthma and associated allergic conditions, *and also is essentially free from the undesirable side actions of ephedrine.*

Clinical tests show NETHAPRIN can be expected to provide effective relief . . . increased vital capacity . . . better feeling of well-being. Yet its bronchodilator, Nethamine, "produces no noticeable pressor action."[1]

## NETHAPRIN®

**SYRUP** **CAPSULES**

Each capsule or 5 cc. teaspoonful contains: Nethamine® Hydrochloride 25 mg., Butaphyllamine® 60 mg., Decapryn® Succinate 6 mg.

When Phenobarbital is preferred to the antihistamine, prescribe NETHAPHYL®—in full or half strength.

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[1]Hansel, F.K.: Ann. Allergy, 5:397, 1947

as a disequilibrium due to loss of one member of a balanced pair rather than as the release of a function by loss of an inhibitory suppression of that function. The bizarre postures of athetosis and dystonia have meaning only as conflicting extremes in the pattern of control of the basic organization of the tegmental mechanism by rolandic and extra-rolandic cortex. There is thus no "center" for spasticity, rigidity or involuntary movements nor may a "pathway" be expected for these functions. Each is the outcome of partial or complete release of a normal component in movement from its natural competitor.

## REHABILITATION OF PATIENTS WITH HEMIPLEGIA

Leonard J. Yamshon, M.D., Los Angeles. In CALIFORNIA MEDICINE, 73:2:181, August 1950.

Patients with hemiplegia can be rehabilitated unless one or another of the following conditions exist: Senility, medical complications prohibiting activity, loss of learning ability, psychosis, lack of motivation, and (sometimes) atonicity.

Motivation is the keystone of rehabilitation. It is of two main types, (1) internal, and (2) external. In internal motivation the impetus to activity arises from within the individual; in external motivation the impetus is provided from the outside. Internal motivation is frequently lost in chronic debilitating illnesses. In order to renew it, external motivation must be supplied as a stimulus.

Rehabilitation is started as soon as medical condition warrants. In cases in which paralysis has been caused by cerebral hemorrhage, activity must wait until all evidence of bleeding ceases.

During the atonie phase, it is important to maintain the range of motion in the joints. Contractures are liable to develop, particularly in older individuals.

Teaching the patient the activities of daily living is started at the onset of treatment. These activities consist of functions which are inherent in everyday existence, such as getting out of bed, standing, dressing, eating, and walking.

Parallel bars may be used in teaching ambulation. The patient first learns to stand and then

(*Continued on page* 58)



**UNTIL her physician can observe and treat her symptoms, many a woman, even today, faces the failing fires of the menopause with confusion . . .**

Physicians who are no longer satisfied with the limited action of replacement therapy alone, are electing to use a MORE COMPREHENSIVE TREATMENT for menopausal disturbances. Specifically designed for this purpose, Tablet Phen-Orivan, Dorsey provides, in addition to estrogenic substances:

*Thyroid to stimulate metabolism and promote a feeling of well being; phenobarbital and hyoscyamus to hasten relief by sedative and antispasmodic action.*

To treat *the entire symptom complex*, and to avoid a *tendency to overtreat* which may prolong the menopausal syndrome, Tablet Phen-Orivan is proving an extremely useful aid to therapy. Have you prescribed it?

**EACH TABLET PHEN-ORIVAN, DORSEY CONTAINS:**

Phenobarbital..... ¼ gr.
Thyroid..... ⅛ gr.
Ext. Hyoscyamus..... ⅛ gr.
Estrogenic substances from pregnant mares' urine, in their naturally occurring, water-soluble, conjugated form, expressed as sodium estrone sulfate.....0.25 mg.

TABLET

*Fresh Fuel...* **PHEN-ORIVAN, Dorsey**

THE SMITH-DORSEY COMPANY, LINCOLN, NEBRASKA • BRANCHES AT LOS ANGELES AND DALLAS

*in hospitals, and with leading hematologists . . .*





# Feosol Tablets *are the standard iron therapy*



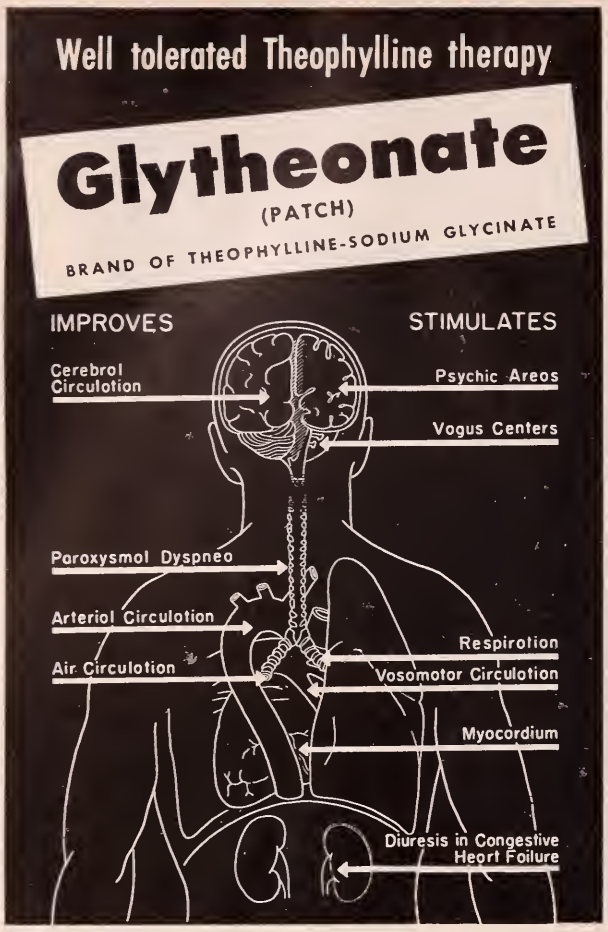
In simple iron-deficiency anemias, Feosol Tablets are standard because they are not only easily tolerated but also remarkably effective.

Feosol Tablets' special coating assures timed disintegration in the acid medium of the stomach and upper duodenum where iron is best absorbed. That is one reason why they are standard in hospitals and with leading hematologists.

Each Feosol Tablet contains 3 grains exsiccated ferrous sulfate, equivalent to approximately 5 grains crystalline ferrous sulfate.

*Smith, Kline & French Laboratories, Philadelphia*

'Feosol' T.M. Reg. U.S. Pat. Off.




**GLYTHEONATE** is a combination of theophylline and sodium glycinate representing 50% theophylline U.S.P.

**GLYTHEONATE** permits intensive oral theophylline therapy with minimal gastric irritation[1,2] in treating bronchial asthma and Cheyne-Stokes respiration, and in relieving paroxysmal attacks of cardiac dyspnea. Indicated in all cases where aminophylline is used.

*Available as:*

**TABLETS** Plain (Uncoated)—containing theophylline-sodium glycinate 325 mg. (5 grs.), representing theophylline U.S.P. 162 mg. (2½ grs.). In bottles of 100 and 500.

**SYRUP**—Each teaspoonful (5 cc.) contains theophylline-sodium glycinate 325 mg. (5 grs.) representing theophylline U.S.P. 162 mg. (2½ grs.). In pint and gallon bottles.

**SUPPOSITORIES** (Rectal)—containing theophylline-sodium glycinate 0.78 Gm. (12 grs.), representing theophylline U.S.P., 0.39 Gm. (6 grs.). Boxes of 12 suppositories.

Also tablets with Phenobarbital, tablets with Phenobarbital and Racephedrine and tablets with Phenobarbital and Rutin.

1. Paul, W. D., and Montgomery, A. E.: J. Iowa State M. Soc. *38*:237 (June) 1948.
2. Bubert, H. M. and Cook, S.: S. Med. Journ. *41*:146 (Feb.) 1948.

THE E. L. PATCH COMPANY, Stoneham, Mass.


## Physical Medicine (Continued)

to walk. Bars are better for this purpose than walkers, since they give the patient a sense of security in that he has something stable to grasp. From the bars the patient is graduated to a cane and finally may be able to walk without support.

Paresis of the arm is more difficult to overcome. Nevertheless good functional recovery as a result of overcoming atrophy of disuse is not uncommon.

Occupational therapy procedures, which have the advantage of keeping the patient interested in improvement, are best suited to treatment of the arm.

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### REHABILITATION OF THE AMPUTEE

Odon F. von Werssowetz, M.D., and Maude W. Baum. In THE MILITARY SURGEON, 107:1:1; July 1950.

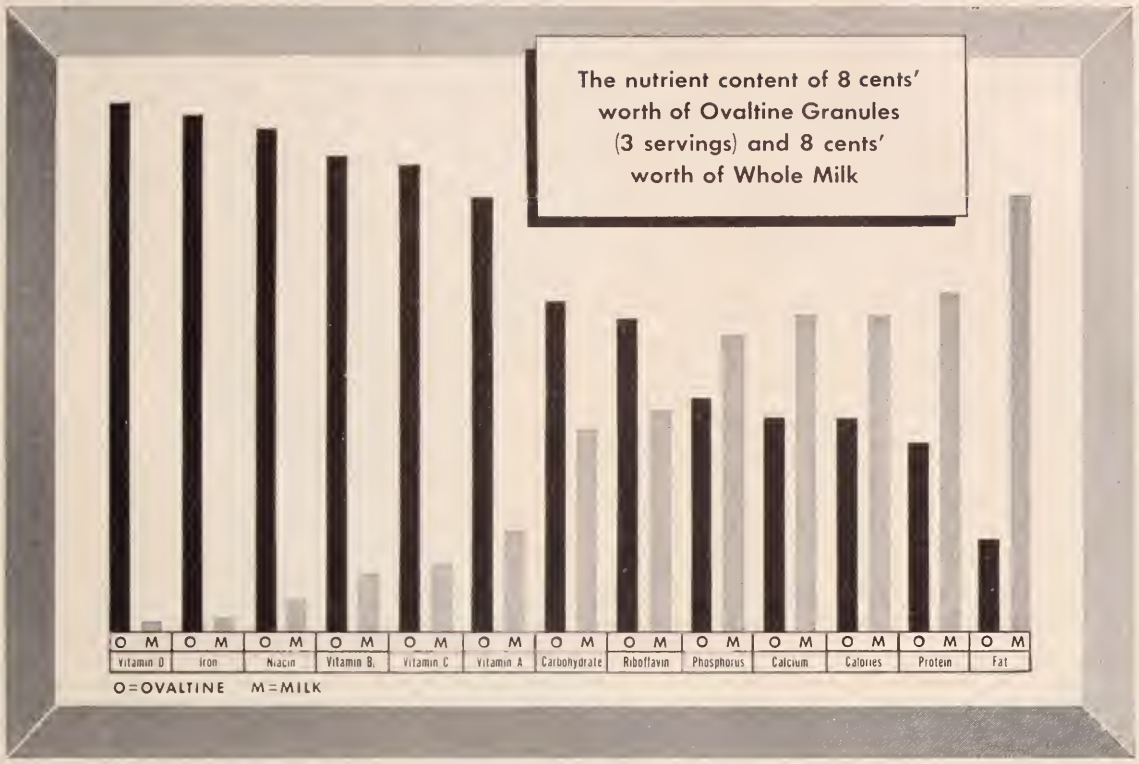
In the total treatment of the amputee, rehabilitation starts before or at the time of the operation and is continued until the patient is returned to the community, prepared to meet satisfactorily the tasks of daily living.

The patient should be prepared psychologically for the operation. This will minimize the mental shock and will prepare him for successful rehabilitation.

Adequate surgery secures a stump which has the optimal lengh for the proposed prosthesis. Functional rehabilitation in the postoperative period must start at the earliest possible moment, even in spite of an open wound that did not heal by primary union. It is better to commence the use of muscles to move the adjacent joints by the end of the first week before they have wasted away, rather than to work for months later in trying to induce them to regain their strength. The patient should be instructed early in good position of the stump to prevent contractures and deformities, which are easily acquired but hard to correct.

The preprosthetic treatment and training prepares the stump for the prosthesis by shrinkage and toughening; the shrinkage is best accomplished by using an elastic bandage and is obtained by planned pressure. This will result in obtaining a properly shaped stump, conical for the standard or conventional prosthesis and cylindrical for the suction socket prosthesis. Muscle imbalance and faulty posture are corrected by

(*Continued on page* 60)




# Note the *Outstanding Economy* of OVALTINE

| NUTRIENTS | OVALTINE* | WHOLE MILK** |
|---|---|---|
| Vitamin D | 400 I.U. | 8 I.U. |
| Iron | 12 mg. | 0.3 mg. |
| Niacin | 6 mg. | 0.4 mg. |
| Thiamine | 0.90 mg. | 0.16 mg. |
| Ascorbic acid | 30 mg. | 4 mg. |
| Vitamin A | 2025 I.U. | 625 I.U. |
| Carbohydrate | 29 Gm. | 19 Gm. |
| Riboflavin | 0.75 mg. | 0.66 mg. |
| Phosphorus | 255 mg. | 363 mg. |
| Calcium | 255 mg. | 460 mg. |
| Calories | 160 | 269 |
| Protein | 6.5 Gm. | 13.6 Gm. |
| Fat | 2 Gm. | 15 Gm. |

* 8 cents' worth of Ovaltine (3 servings)
** 8 cents' worth of milk

As the bar chart so vividly indicates, Ovaltine is an exceptionally economical source of many essential nutrients. Using whole milk as the basis for comparison, the chart contrasts the relative amounts of nutrients supplied by 8 cents' worth of Ovaltine granules (3 servings) and by 8 cents' worth of whole milk. In 8 of the 13 nutrients listed, Ovaltine supplies greater amounts, and in the remaining 5, high proportions of the amounts found in milk.

It should be noted that Ovaltine specially enriches milk in those nutrients in which milk is low. Thus Ovaltine is not only economical in use but constitutes with milk an ideal protective supplementary food drink. It finds wide usefulness whenever dietary supplementation becomes necessary, either because of poor appetite, inability to consume a normal diet, or illness which often makes normal eating difficult or impossible.

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**Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritianal content.**

active exercises. These exercises should be gradually progressive from mild to heavy resistive.

Proper fitting and alignment of the prosthesis is the most important phase of the rehabilitation. Because shrinkage and seasoning of the stump requires considerable time, it is found from practical experience that the prosthesis should be fitted early. Later the socket should be altered so as to make it conform with changes of the stump. This will prevent faulty habits of walking or function. In addition, early weight-bearing in the lower extremity is essential and is the only practical way to toughen a stump.

Training in the use of the prosthetic device should be under the supervision of a qualified instructor, who has a thorough knowledge of kinesiology and recognition of the possibilities and limitations inherent in the use of a prosthesis. For the lower extremity amputee, the instructor should be a qualified physical therapist; and for the upper extremity amputee, a qualified occupational therapist. During training, especially of the lower extremity amputee, good habits and patterns of motion should be insisted upon at all times. Only under exceptional conditions should substitutive motions be permitted. The successful and effective wearing of a prosthesis depends largely on the psychological adjustment of the patient in learning to use it.

Successful rehabilitation of an amputee is not completed and the medical responsibility is not ended until the patient has obtained maximal training in activities inherent in daily living and is able to compete economically with normal people, despite his handicap.

## PAIN AND CONTRACTURE IN POLIOMYELITIS

Arthur C. Guyton, M.D., and Robert C. Reeder, B.A., University, Miss. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 63:6:954, June 1950.

On the basis of personal experience of one of us (A.C.G.) and of his contacts with other patients, the pain of poliomyelitis is described as that commonly observed after a muscle bruise or after severe exercise, or that of a stiff neck after one has been sleeping in a cold breeze.

(*Continued on page 62*)

*Cafergone "... was developed primarily for the relief of migraine attack. It is uniformly effective ... for the relief of vascular headache of all other types ..." (Hansel)*[1]

For the first time, clinical studies show that migraine and other vascular headaches can be aborted with *oral medication.*

The cause of migraine is still obscure. The mechanism of head pain, however, is known. Head pain in migraine and related disorders is produced by abnormal dilatation of certain cranial arteries, principally branches of the external carotids. Gastrointestinal upset (especially vomiting) is also characteristic of the syndrome.

Recently attention has centered on the development of an *effective oral preparation.* Cafergone (ergotamine tartrate 1 mg.; caffeine 100 mg.) resulted from this research. The vasoconstrictor action of *ergotamine* is well known. *Caffeine* orally aids this effect. As a result, simultaneous administration in Cafergone tablets reduces the oral dosage of ergotamine required for relief.[2, 3]

Dosage: Two Cafergone Tablets at first sign of impending attack and additional 1-tab. doses (up to 6) at ½ hour intervals as required. *Reprints of papers and brochures available for data on dosage adjustment and other particulars.*

Partial Bibliography on Cafergone

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Sandoz Pharmaceuticals

DIVISION OF SANDOZ CHEMICAL WORKS, INC.
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A vaginal jelly or cream with too heavy a viscosity is apt to remain in the posterior fornix and latently come in contact with the sperm. A lubricant with a very light viscosity tends to reduce required chemical barrier film. Koromex Jelly and Cream have the ideal viscosity determined by many years of laboratory tests and patient approval.

ACTIVE INGREDIENTS: BORIC ACID 2.0% OXYQUINOLIN BENZOATE 0.02% AND PHENYLMERCURIC ACETATE 0.02% IN SUITABLE JELLY OR CREAM BASES

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MERLE L. YOUNGS PRESIDENT

## Physical Medicine (Continued)

Experimental studies on ischemic pain in the arm of human subjects suggest that this type of pain is not the same as that of poliomyelitis.

Studies on ischemia in the legs of dogs, as well as in the arms of human subjects, showed that blood flow must be stopped 90 to 95 per cent of the time in order that pain may be produced. There is no evidence that this degree of ischemia exists in the muscles in poliomyelitis.

In 25 dogs, anterior rhizotomy, a type of lesion physiologically resembling the lesion of poliomyelitis, invariably caused sensitivity in the affected leg. Contracture, typical of that seen in poliomyelitis, also followed. It is concluded, therefore, that the pain and contracture in poliomyelitis are probably due to local pathologic changes in the muscle following denervation.

It is postulated that the pain of poliomyelitis may be caused by products of cellular degeneration and that the value of vasodilation in the treatment of this symptom is the increased removal of such products.

Neurogenic spasm as a cause of contracture and pain is discussed, and it is concluded that there is no evidence to support such a concept, chiefly because even totally paralyzed muscles undergo the same type of contracture as do other muscles.

### THE EFFECT OF PARALYSIS OF ONE LOWER-EXTREMITY ON BONE GROWTH: PRELIMINARY REPORT

Glenn Gullickson Jr., M.D., M. Olson, B.S., and F. J. Kettke, M.D., Minneapolis, Minn. In ARCHIVES OF PHYSICAL MEDICINE, 31:6:392, June 1950.

Eighty-eight cases of chronic poliomyelitis with unilateral involvement of a lower extremity in patients 6 months to 14 years of age at onset were examined three to seven years later. The relation between muscle strength, atrophy and discrepancies in growth of the involved femur, tibia and total lower extremity were analyzed. No correlation was found between muscle strength of the leg and shortening of the tibia. Significant but very poor correlation was found between the muscle strength of the high and shortening of the femur. There was a definite correlation between atrophy of the thigh or leg and shortening of the femur or tibia, between total strength of the involved extremity and shortening in that extremity and between total atrophy

(*Continued on page 64*)



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## Physical Medicine (Continued)

and shortening of the involved extremity. The age at which acute poliomyelitis occurred appeared to bear no relation to the amount of shortening up to the time of bone maturity. The factors which may be related to soft tissue atrophy and diminution of bone growth have been considered.

### AN ANALYSIS OF PARALYTIC THUMB DEFORMITIES

J. Leonard Goldner, M.D., and C. E. Irwin, M.D., Warm Springs, Ga. In THE JOURNAL OF BONE AND JOINT SURGERY, 32-A:3:627, July 1950.

Paralysis of the opposition unit of the thumb is a major disability. The degree of deformity depends primarily upon the anterior-horn cells affected, and the treatment hinges upon the resulting deformity. Furthermore, the status of the thumb is not constant, and the secondary changes which occur in bones, joints, and soft tissues make an ideal end result difficult. The factors of nerve supply, muscle strength, joint contractures, joint stability, and vascular status must all be considered. The interval from onset of disease, the occupation, the general physical condition, and the stability of the remainder of the arm and forearm must be evaluated before reconstruction is attempted. The treatment of each thumb will vary according to the pathological changes present. With these facts in mind, a general classification is outlined, and the variations in treatment are discussed.

### THE PUNCHING BAG IN REHABILITATION

J. L. Rudd, M.D., and Reuben J. Margolin, M.A., Boston, Mass. In THE JOURNAL OF BONE AND JOINT SURGERY, 32-A:3:698, July 1950.

A valuable piece of exercise equipment for a medical gymnasium — potentially useful, but seldom employed — is the punching bag. It is readily available; the overhead platform drum is easily constructed; and it is inexpensive.

In any exercise program, one of the first factors to be considered is avoidance of the monotony and boredom of the routine prescription. A second factor is the improvement of a specific pathological condition as a result of the activity.

Carefully selected cases of shoulder disability

(*Continued on page 66*)



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have been treated by the use of the inflated pear-shaped leather bag, in addition to the usual physical, occupational, and corrective therapy. A number of diseases and injuries of the upper extremities, especially in the region of the shoulder and elbow, are amenable to this type of corrective therapy. Patients with subdeltoid or subacromial bursitis, as well as those with dislocation or fracture of the shoulder or elbow joint, can expect gains in strength and in range of motion in specific planes.

In certain conditions, we were able to aid the patient in regaining an appreciable measure of coordination and rhythm. Few gymnasium exercises require a greater synergistic action of muscles than striking the bag. Rhythmic mental responses foster the element of awareness, aid in reestablishing the reflex arc, and combat what may be a very disabling psychological block or "mental alienation."

All punching-bag exercises should progress from the very simple to the more complex. The patient should learn to strike the bag in a manner which will benefit his particular condition.

---

### REHABILITATION OF COMMON NEUROMUSCULAR DISORDERS

George Morris Piersol, M.D., Philadelphia, Pa. In POSTGRADUATE MEDICINE, 8:1:38, July 1950.

The purpose of this clinic is to demonstrate what a carefully integrated and patiently carried out rehabilitation program can do for individuals who by reason of injury or disease have been so badly crippled that without further aid they would become complete charges on the community and individuals with discouraging futures.

The first problem in the rehabilitation of these individuals was to get them to navigate, so they can move around. A person who is down, unable to stand, balance, or get from place to place is under a tremendous disadvantage.

The attention of those who care for these people cannot be directed merely toward their lower extremities, or any single part that is in-

(*Continued on page* 68)


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## Physical Medicine (Continued)

volved: the *whole* patient has to be considered. Efforts have to be made to build up their remaining good musculature to the point where it is able to carry a much greater load than normally it would be required to do.

It has been shown that individuals with appliances, in making ordinary effort such as getting out of a wheelchair, will expend energy many hundreds of times greater than that which a normal person requires to perform the same act.

Our primary purpose is to get people back to a point where they can do the maximum amount and take as much care of themselves as possible. In order to do that, as Doctor Deaver has repeatedly emphasized, one must be prepared to abandon preconceived notions and be governed chiefly be practical considerations.

---

## CLINICAL POLIOMYELITIS IN ASSOCIATION WITH PERIPHERAL INOCULATION OF PROPHYLACTICS

F. O. MacCallum, M.D., B.Sc. In BRITISH MEDICAL JOURNAL, No. 4669, p. 6, July 1, 1950.

Poliomyelitis virus has been isolated from the stools of two children who had paralysis of a limb inoculated 11 and 12 days previously with certain vaccines.

The virus has also been isolated from the stools of three children who developed poliomyelitis or encephalitis 5 o 17 days after receiving a prophylactic inoculation without localization of paralysis in the inoculated limb.

It is recognized that the poliomyelitis virus is widespread during epidemic times, and no suggestion is made here that the viruses isolated were necessarily responsible for the present illness of the patients. These strains will be used, however, for experimental investigation of the problem of the effect of peripheral trauma in precipitating poliomyelitis or localization of paralysis in patients infected with or carrying poliomyelitis viruses.

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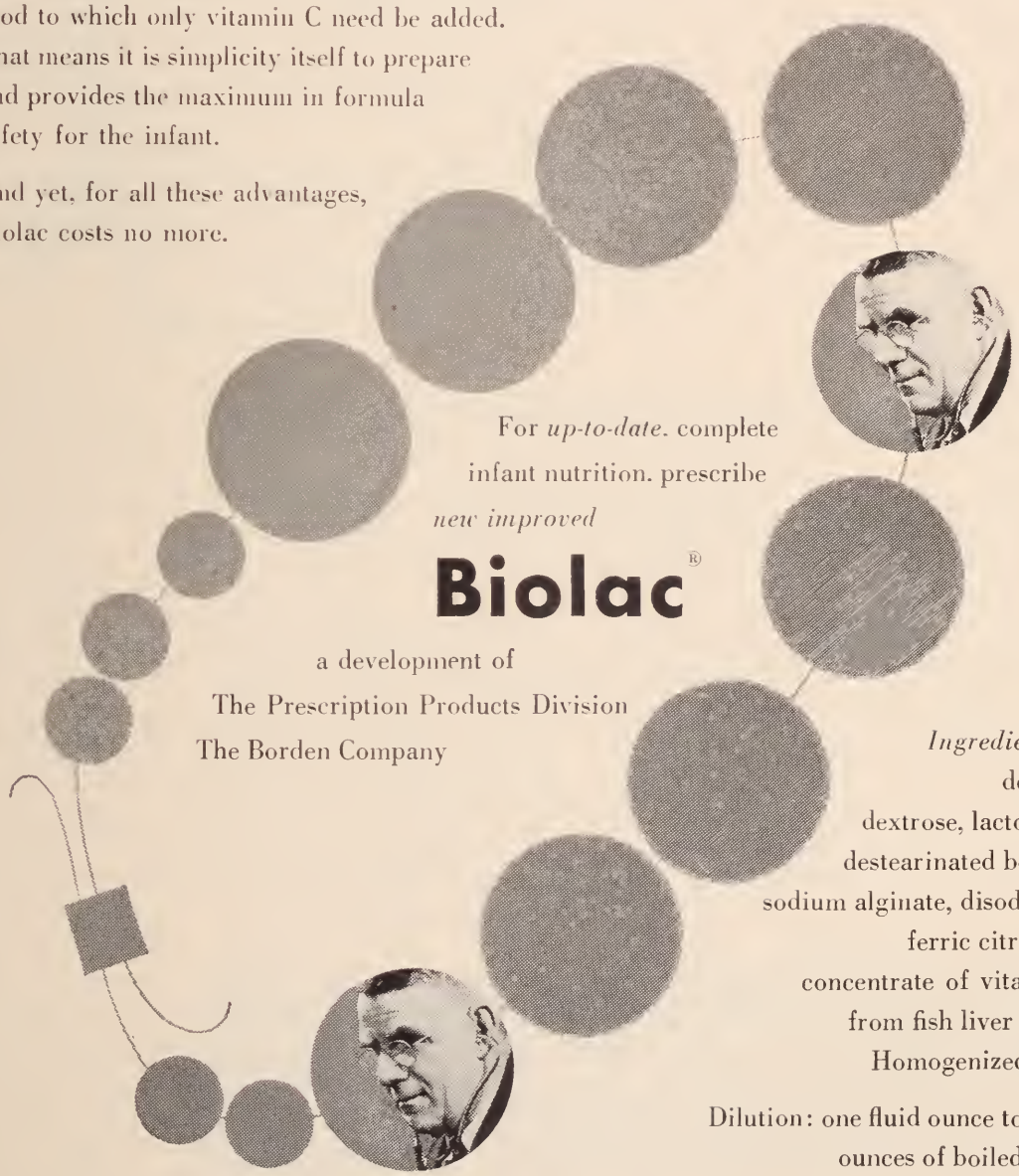
Modern public health does not prevent death alone. It also prevents disease. For every life preserved by a tuberculosis program, scores of individuals are saved from invalidism. For every life saved from malaria, hundreds of individuals are maintained as active producers in the population. Am. J. Pub. Health, August 1950.

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# BOOK REVIEWS



Textbook Of Medical Treatment. By Various Authors. Edited by D. M. Dunlop, B.A. (Oxon.),M.D., F.R.C.P. (Edin.), F.R.C.P. (Lond.), Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Physician, Royal Infirmary, Edinburgh. L.S.P. Davidson, B.A. (Camb.), M.D., F.R.C.P. (Edin.), F.R.C.P. (Lond.), M.D. (Oslo), Physician, H.M. the King in Scotland; Professor of Medicine and Clinical Medicine, University of Edinburgh; Physician, Royal Infirmary, Edinburgh; Formerly Regius Professor of Medicine, University of Aberdeen, and J. W. McNee, D.S.O., D.Sc., M.D. (Glas.), F.R.C.P. (Edin.), F.R.C.P. (Lond.), Physician, H.M. the King in Scotland; Regius Professor of Practice of Medicine, University of Glasgow; Physician, Western Infirmary, Glasgow; Consulting Physician, University College Hospital, London. 5th Ed. 999 Pages. Williams and Wilkins, Baltimore. 1949. $8.50.

The popularity of this book can be judged by the fact that this is the fifth-edition since 1939. It is not a textbook of pharmacology nor an encyclopedia of treatment, but is intended to be a guide to the physician concerned with the management of the patient as a whole.

It is complete and well written by a distinguished group of clinicians. The only disadvantage it suffers from is the progress made in medicine since its printing; and the same is true of any textbook or therapeutics.

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Psychological Medicine; A Short Introduction To Psychiatry With An Appendix On Psychiatry Associated With War Conditions. By Desmond Curran, M.B., F.R.C.P., D.P.M., Psychiatrist and Lecturer in Psychological Medicine, St. George's Hospital. Civil Consultant in Psychological Medicine to the Royal Navy; and the late Eric Guttmann, M.D., M.R.C.P., Formerly Clinical Director, the Maudsley Hospital, London, Etc. 3rd Ed. 252 Pages. Williams and Wilkins, Baltimore. 1949. $4.00.

This small book is intended as an introduction to psychiatry for student and practitioner. In spite of its brevity it covers the general field of psychiatry rather well. Medical as well as psychiatric treatment is given in some detail. There is an appendix on wartime psychiatry which is excellent.

Only a few minor criticisms are noted, such as the use of tradenames for some drugs, for instance somnifaine, which may not be familiar to American readers.

An important point that cannot be emphasized too much is brought out by this book; that is avoidance of fixation of symptoms by unnecessary clinical and laboratory studies.
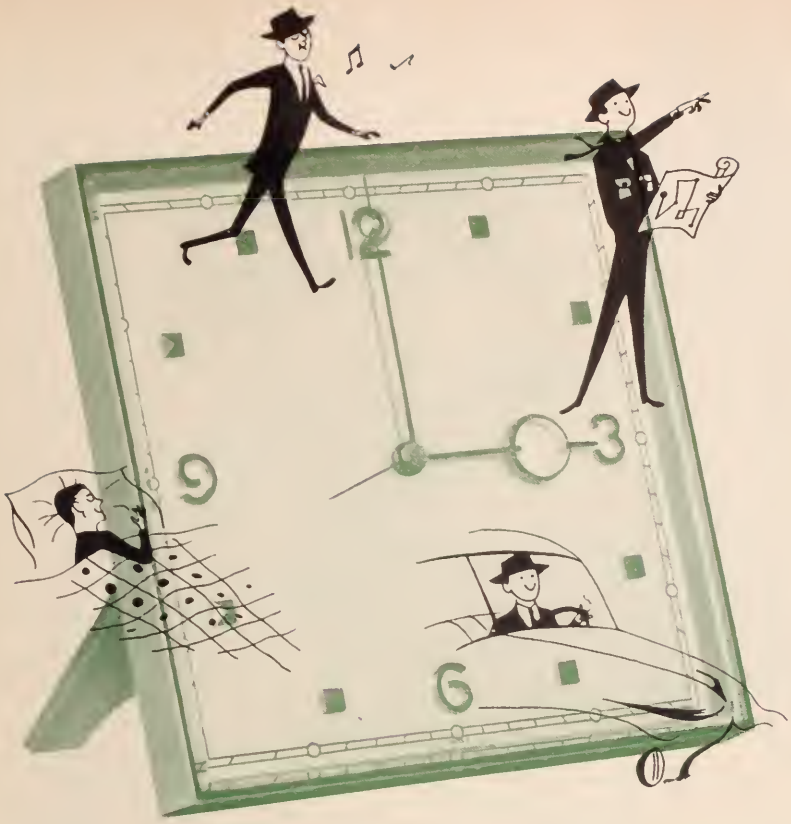
J. C. S.

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Tuberculosis: A Discussion of Phthisiogenesis, Immunology, Pathologic Physiology, Diagnosis and Treatment. By Francis Marion Pottenger, A.M., M.D., Ll.d., F.A.C.P. Emeritus Professor of Medicine, Univ. of Southern California, The School of Medicine; Medical Director, The Pottenger Sanitorium and Clinic for Diseases of the Chest, Monrovia, Calif. 598 pages, 105 illustrations, $12.00, St. Louis, C. V. Mosby Co. 1948.

If the author of this new book were a resident of Illinois he would be an honored member of our Fifty-Year Club, since he has practiced medicine in his

(*Continued on page 72*)



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# 'Round-the-clock relief from 4 small doses

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1. "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—" . . . Sheldon, J.M. Et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948)
2. "It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—" . . . MacQuiddy, E.L.: Neb. State M.J. 34:123 (1949)

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## BOOK REVIEWS (Continued)

specialty of tuberculosis for more than 50 years. He has written a careful study of his observations in that line with a good deal of emphasis on the pathogensis of Tuberculosis. He looks upon tuberculosis as a mildly infectious disease; he believes primary infection is a vaccination which offers specific protection; and he definitely regards tuberculosis as a curable disease.

Dr. Pottenger has his own ideas on physical findings in Tuberculosis, and the emphasis he puts on physical examination is proper and should be remembered by all of us. It is too easy to treat the tuberculosis patient by following his progress with x-ray and laboratory aids alone: but as Dr. Pottenger points out, one must treat the patient, not the shadows he casts on an x-ray film.

This book is well written in an original, informal way which makes for easy reading. The x-rays are for the most part well reproduced. Recommended for anyone with special interest in tuberculosis.

J. C. S.

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Types of Diabetes Mellitus and Their Treatment, Arthur R. Colwell, M.D., Associate Professor of Medicine and Director of Medical Specialty Training, Nortwestern University Medical School; Attending physician, Evanston Hospital; Consulting Physician, Wesley Memorial Hospital, Municipal Tuberculosis Sanitarium, Chicago, Illinois. Charles C. Thomas, Publisher, 1950, Springfield, Ill. 97 pp. Price $2.00

This is publication No. 67 of the American Lecture Series.

This 97-page booklet is devoted to Definition, Clinical Varieties, four "groups" instead of chapters, and a bibliography.

Group I. Unproved Diabetes—Diagnosis.

Group II. Mild Diabetes—Treatment by Diet.

Group III. Severe Diabetes—Treatment with Insulin.

Group IV. Acute Complications—Emergency Treatment.

Pages 24 to 47 are devoted to treatment by diet. This is an interesting discussion which every internist and general practitioner will find instructive and helpful, though not all will emphasize, as the author does, the importance of weighing the diet.

Group III contains an interesting discussion of various kinds of insulin and their time reactions.

Group IV describes the treatment of emergencies, advising the administration of carbohydrate with insulin. There are two schools of thought about this. Robert D. Story in the J.A.M.A. September 9, 1950, page 86, condemns the early use of dextrose in the treatment of diabetic coma.

Mr. Thomas has gotten out this booklet in his usual beautiful manner. It is a worthwhile addition to the library of every internist and general practioner. Reading it would do the surgeons no harm.

J. H. H.



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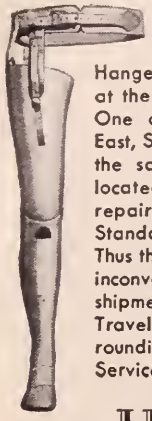
(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Otent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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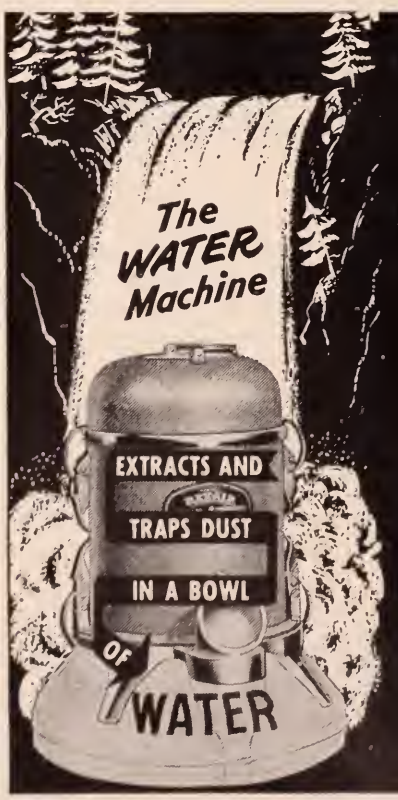
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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SURGERY OF THE EYE: INJURIES: By Alston Callahan, B.A., M.S., (Ophth.), M.D.F.A.C.S. Charles C. Thomas, Publisher, Springfield, Illinois. 217 pages. $11.50.

SEROLOGY WITH LIPID ANTIGEN — With special reference to Kahn and universal reactions. By Reuben L. Kahn, M.S., D.Sc. The William & Wilkins Company, Baltimore. 327 pages. $6.00.

SANTA CLAUS, M.D., By W. W. Bauer, M.D., The Bobbs-Merrill Company, Inc., Indianapolis, New York. 266 pages. $2.75.

THE PROSTATE GLAND. By Herbert R. Kenyon, M.D. Random House, New York. 194 pages. $2.95.

PRINCIPLES OF INTERNAL MEDICINE: T. R. Harrison, Editor-in-Chief. Paul B. Beeson, William H. Resnik, George W. Thorn, M. M. Wintrobe, Editors. The Blakiston Company, Philadelphia and Toronto. 1590 pages. $12.00.

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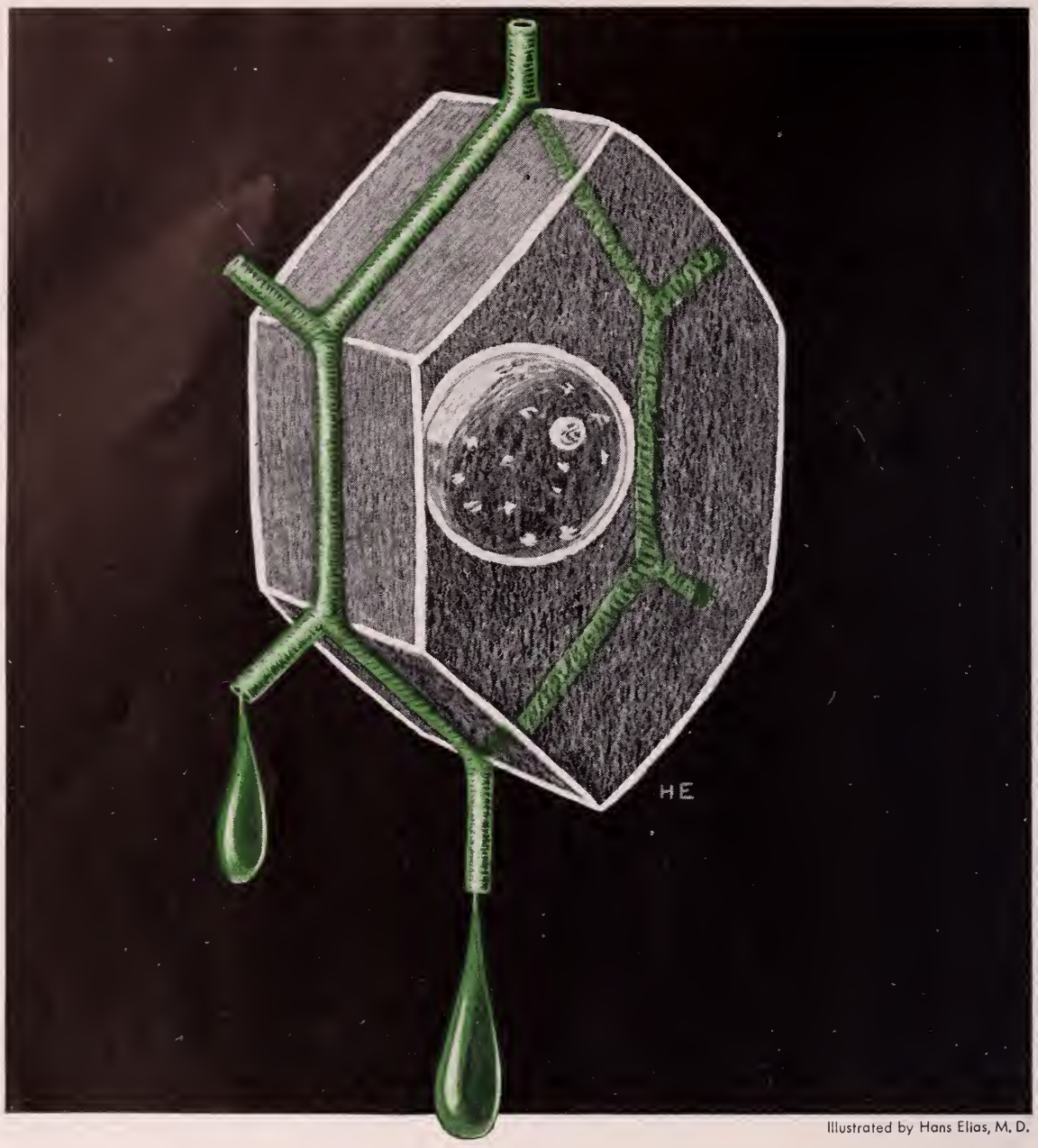
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December, 1950

## SEASON'S GREETINGS

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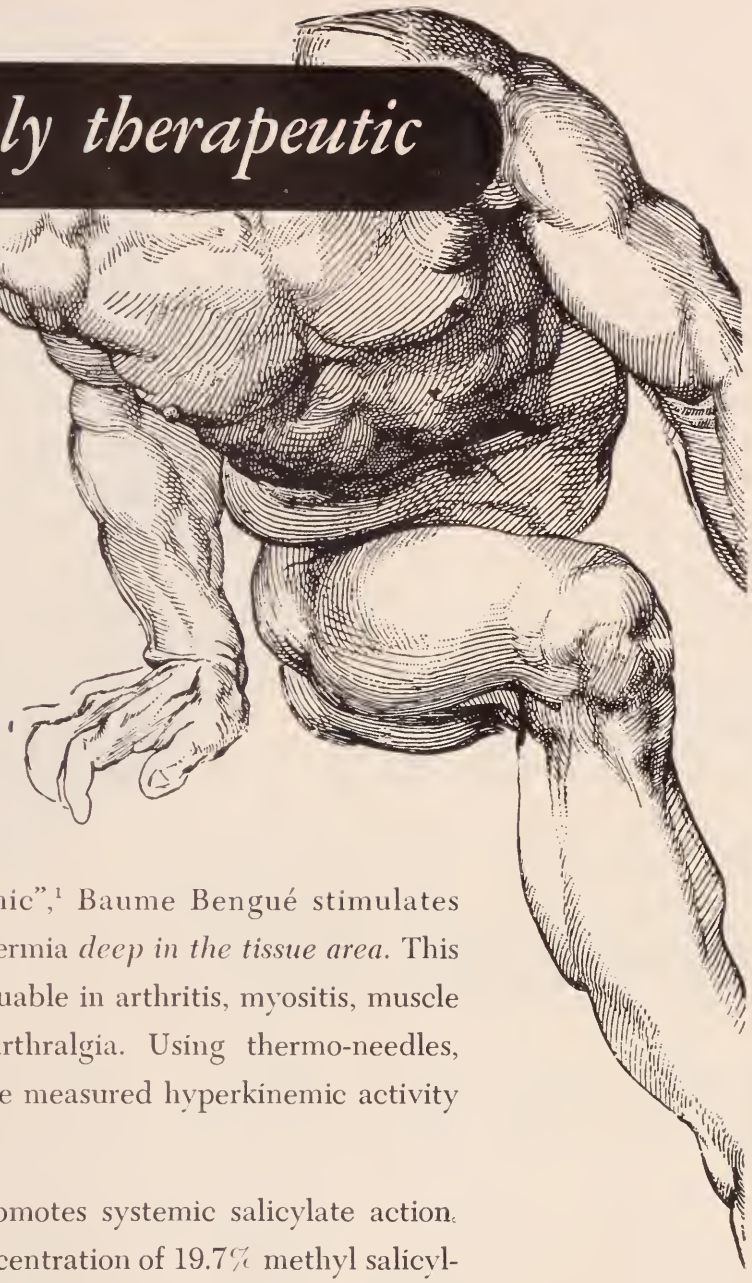
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*1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.*

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1. Rogers, Max P.: J.A.M.A., May 21, 1949
2. Wyatt, Bernard L.: Ann. West. Med. & Surg., Aug. 1949
3. Grimson, Marzoni, Reardon & Hendrix: Ann. Surg., 127:5, May 1948


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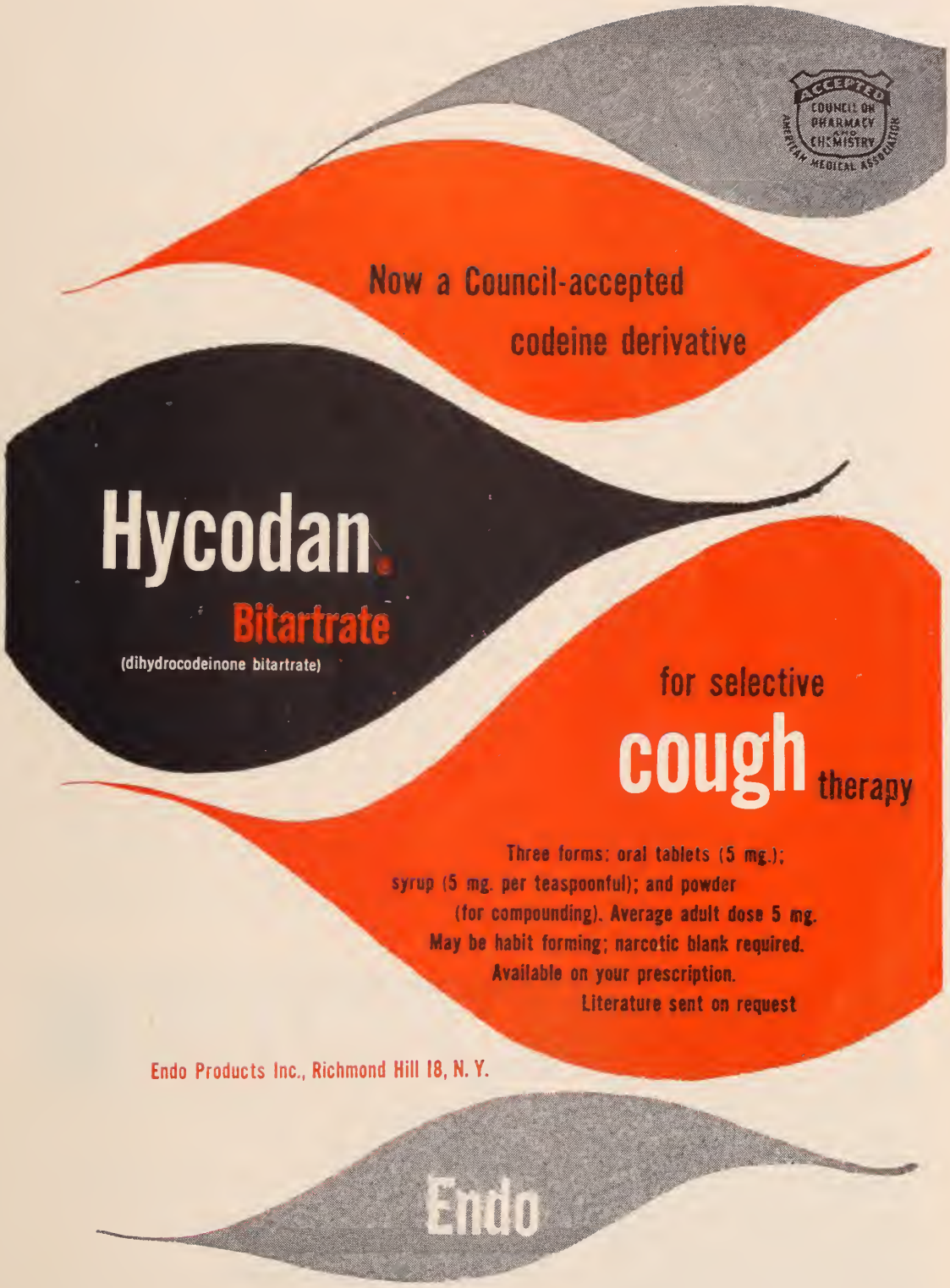
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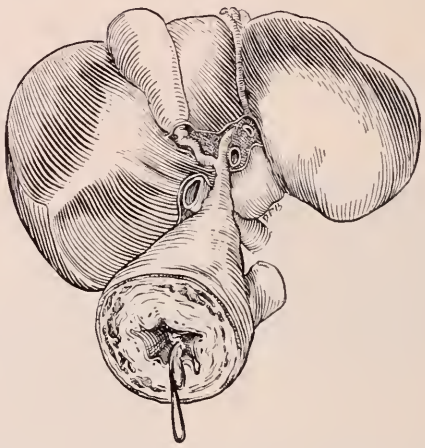
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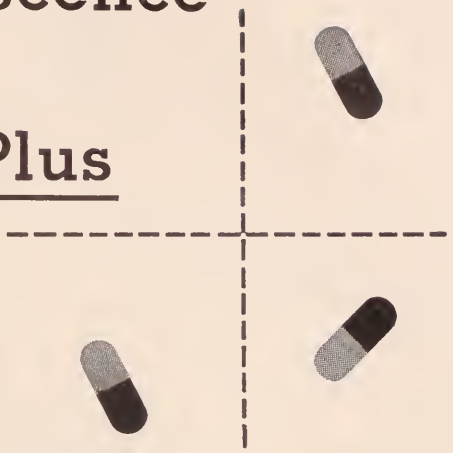
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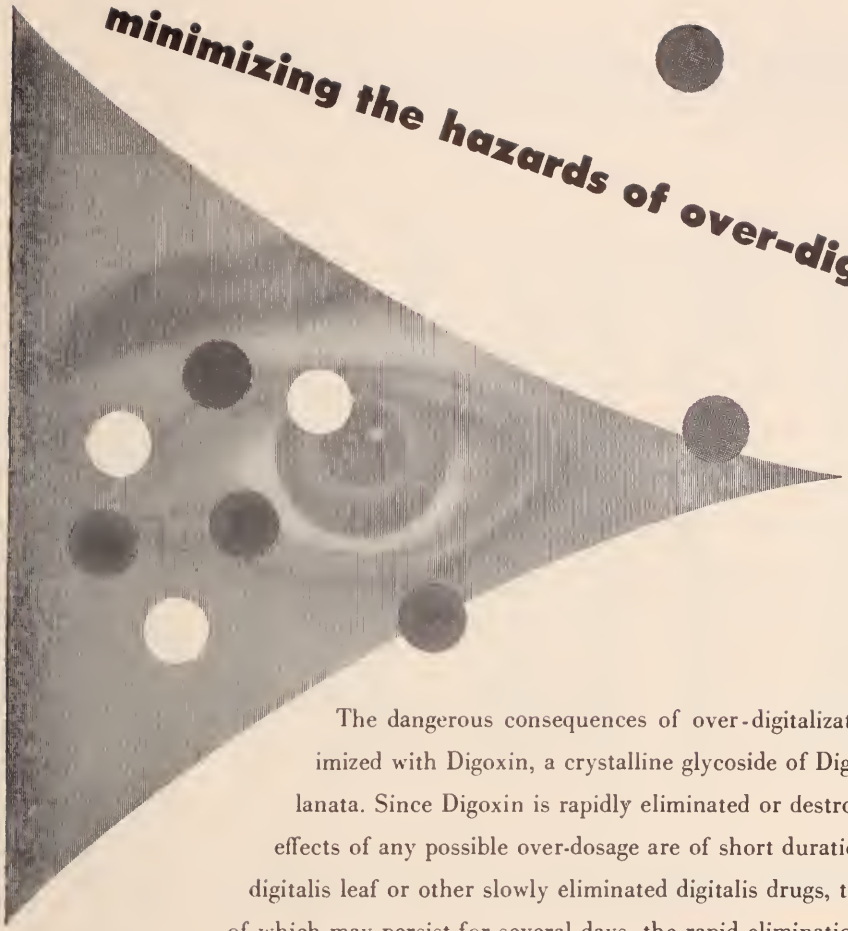
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1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet. & Gynec. 57:541, 1949.
2. Chesley, R. F., and Annitto, J. E.: Bull. Margaret Hague Mat. Hosp. 1:68, 1948.
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5. Neary, E. R.: Am. J. Med. Sc. 212:76, 1946.


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When the patient settles down to "the completion of life", depression can so easily get the upper hand. The seemingly endless, daily routine of living is approached with apathy, inertia and lack of interest; and the patient's own outlook on life drags her down the path to eventual break-up—physical as well as mental.

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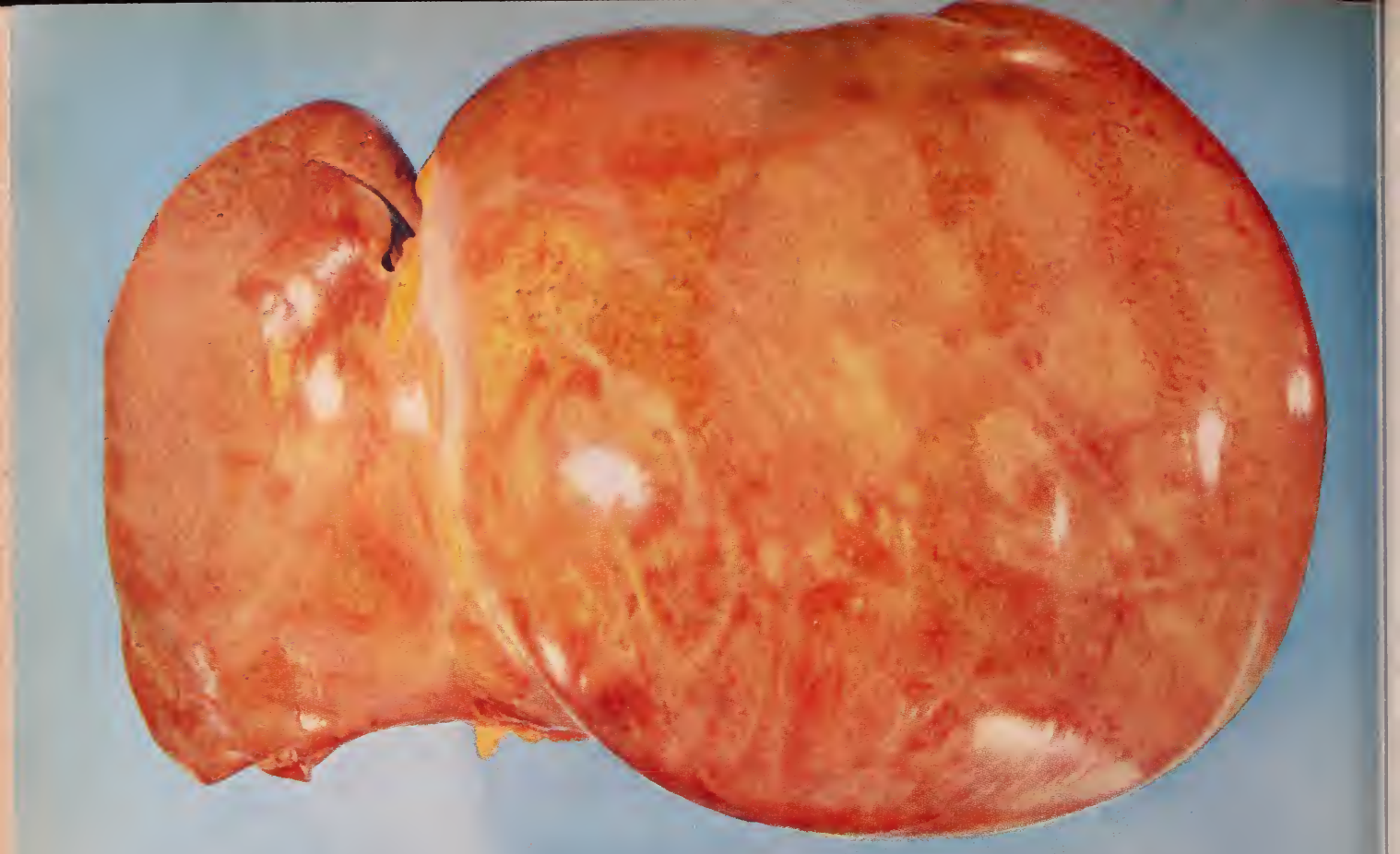
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the antidepressant of choice tablets • elixir

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Actual photograph of a liver (weight, 2800 grams). The underlying parenchyma is greasy and diffusely orange-red. Pathologist's diagnoses: "obesity; left ventricular hypertrophy; pulmonary edema and congestion; fatty infiltration of liver; fatty infiltration of pancreas."

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**2** . . . light up your present brand

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**YES,** your own *personal experience* confirms the results of the clinical and laboratory tests.* With proof so conclusive, would it not be good practice to suggest PHILIP MORRIS to your patients who smoke?

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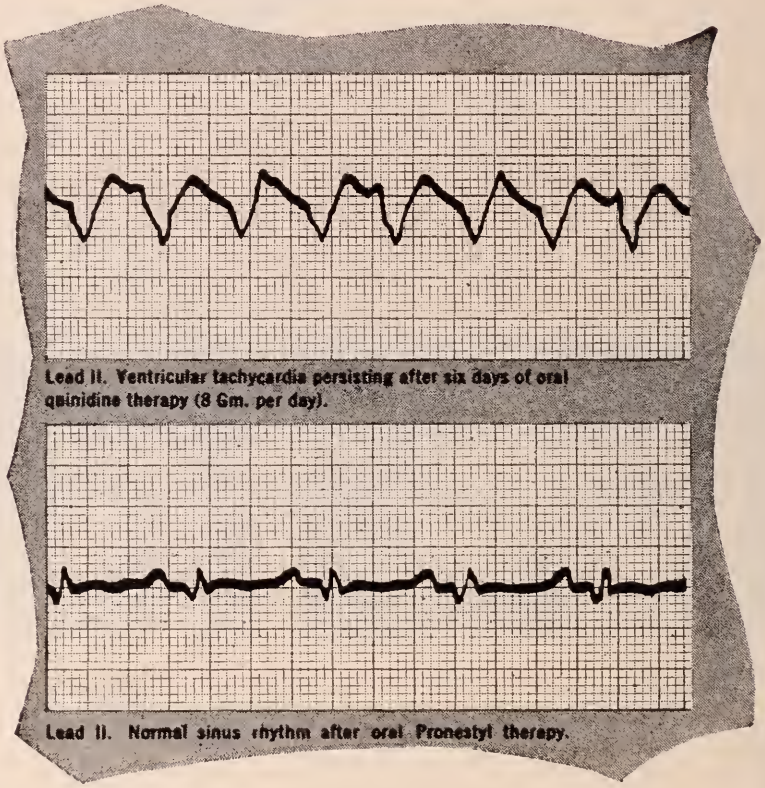
**Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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1. Blake, F. G.; Friou, G. J., and Wagner, R. R.: Yale J. Biol. and Med. 22:495 (July) 1950.

2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.

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Trade Mark

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- Synergistically increased antibiotic activity
- Drug-fastness reduced

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**Penicillin S-R *with* Dihydrostreptomycin**

(Parke-Davis Penicillin and Dihydrostreptomycin Sulfate)

Each 4 cc. with aqueous diluent contains:

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| Crystalline procaine penicillin-G | 300,000 units |
| Crystalline sodium penicillin-G | 100,000 units |
| Dihydrostreptomycin (as the sulfate) | 1.0 Gm. |

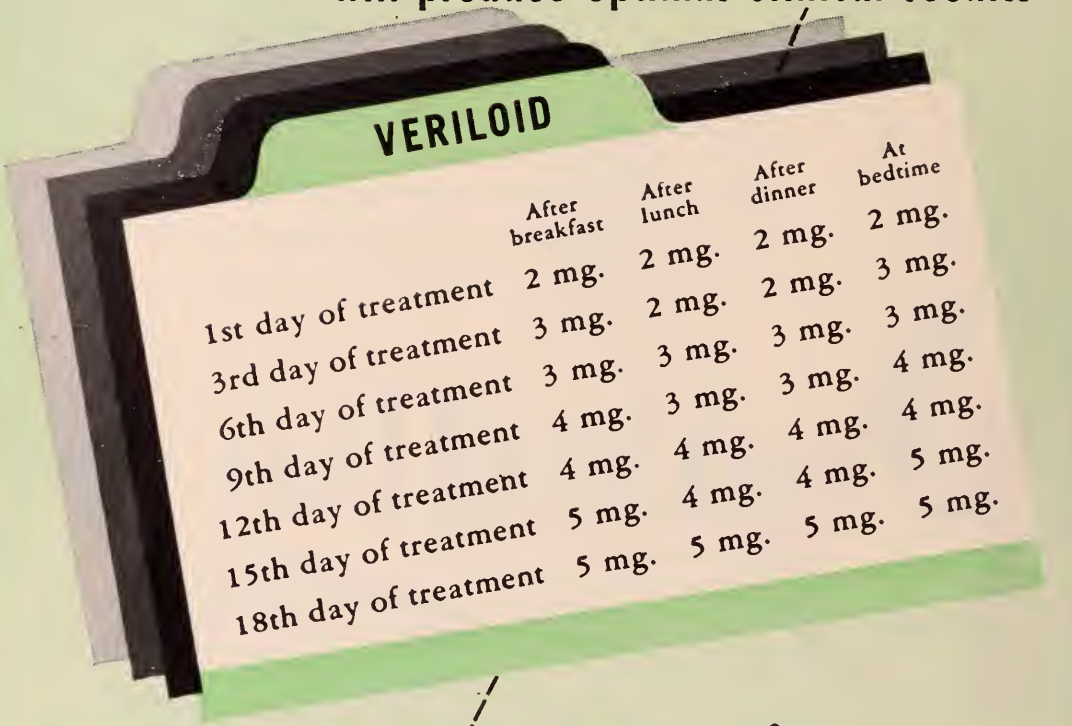
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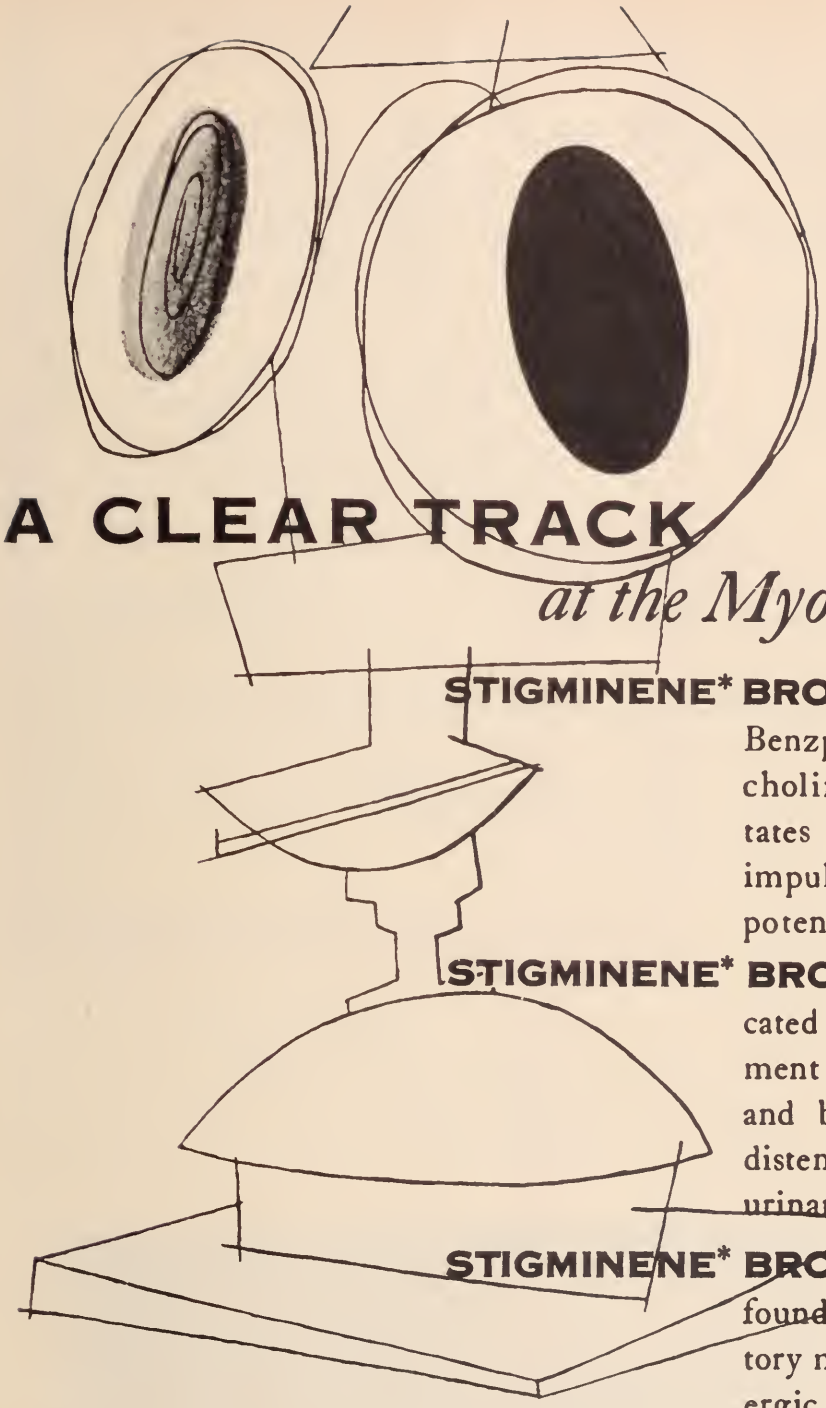
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**STIGMINENE* BROMIDE** *'Warner'* is indicated in the prevention or treatment of postoperative intestinal and bladder atony, abdominal distention, paralytic ileus, and urinary retention.

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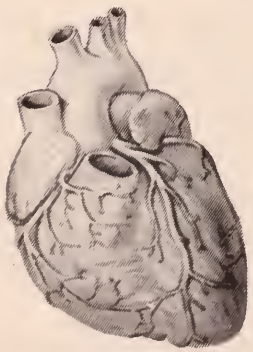
**PACKAGE INFORMATION:** Stigminene* Bromide is available in 1-cc ampuls of a 1:2000 solution, 0.5 mg each, for intramuscular or subcutaneous injection, cartons of 12 and 50 ampuls.

**WILLIAM R. WARNER**
Division of Warner-Hudnut, Inc.
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*Trade Mark

# These are the results you may expect with **ESKEL** in ANGINA PECTORIS

| | |
|---|---|
| *Armbrust, C. A., Jr., and Levine, S. A.: Am.J.M.Sc. 220:127* | "About 60% of the cases showed improvement; i.e., used fewer nitroglycerin tablets, had fewer and milder attacks of pain and could walk greater distances." |
| *Rosenman, R. H., et al.: J.A.M.A. 143:160* | "Of 14 patients with angina pectoris treated with [Eskel] . . . a good response was obtained in 11, moderate improvement in 1 and no effect in 2." |
| *Osher, H. L., and Katz, K. H.: Boston M. Quart. 1:11* | "[Eskel] therapy produced definite subjective and objective improvement in 84% of 19 patients with angina pectoris." |



## ESKEL

**the new longer-acting coronary vasodilator for the prophylaxis and treatment of ANGINA PECTORIS**

'Eskel' T.M. Reg. U.S. Pat. Off.

Each 'Eskel' tablet contains a natural blend of active principles, chiefly khellin, extracted from the plant Ammi visnaga, equivalent to 40 mg. of crystalline khellin.

*Smith, Kline & French Laboratories, Philadelphia*

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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.

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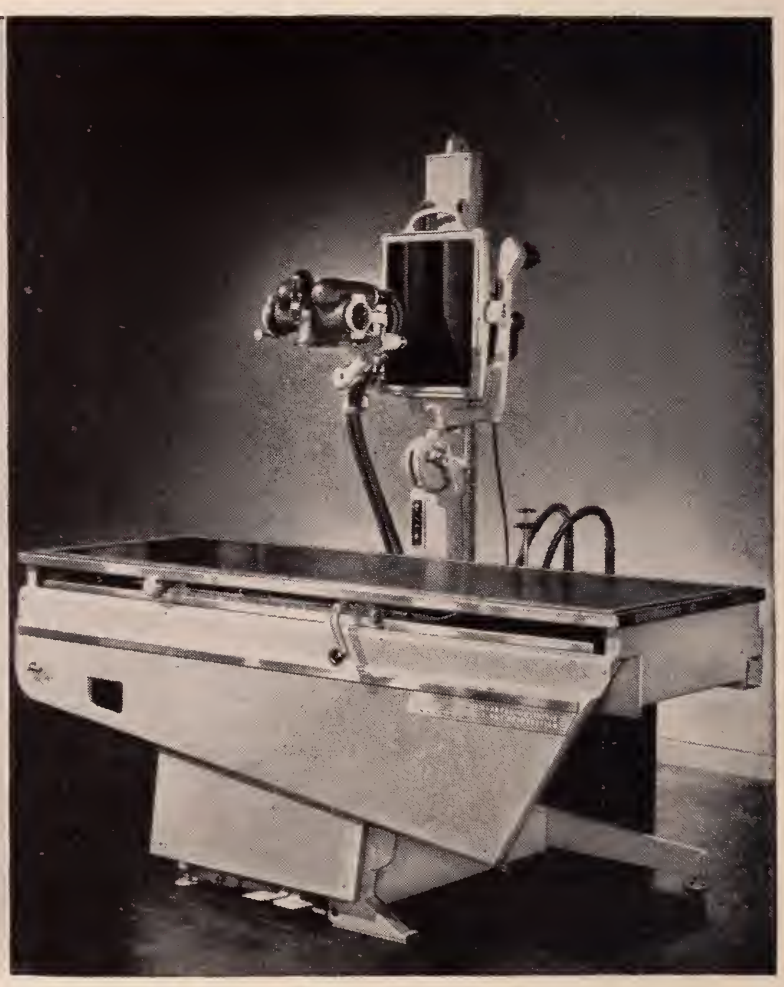
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In Robitussin, Robins now makes available a potent new and different therapeutic weapon for the relief of cough. Its major component is glyceryl guaiacolate, shown by recent dependable investigative techniques to be unexcelled for its intense and prolonged action in increasing R.T.F. (respiratory tract fluid).[1,2,3] Also included in the Robitussin formulation is desoxyephedrine—an adrenergic agent to prevent bronchial spasm[5]—which lifts mood and improves patient's sense of well-being.[4] Robitussin's highly palatable aromatic syrup vehicle appeals to young and old alike. Robitussin makes expectoration easier and freer and diminishes dry, irritating cough. It is non-toxic, non-narcotic.

**USES** Acute colds of head and chest, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, influenza and measles. Helpful as a palliative of harmful cough in tuberculosis, asthma and paranasal sinusitis.

**FORMULA** Each 5 cc. (1 teaspoonful) of Robitussin contains:

| | |
|---|---|
| Glyceryl guaiacolate | 100 mg. |
| Desoxyephedrine hydrochloride | 1 mg. |

In a palatable aromatic syrup

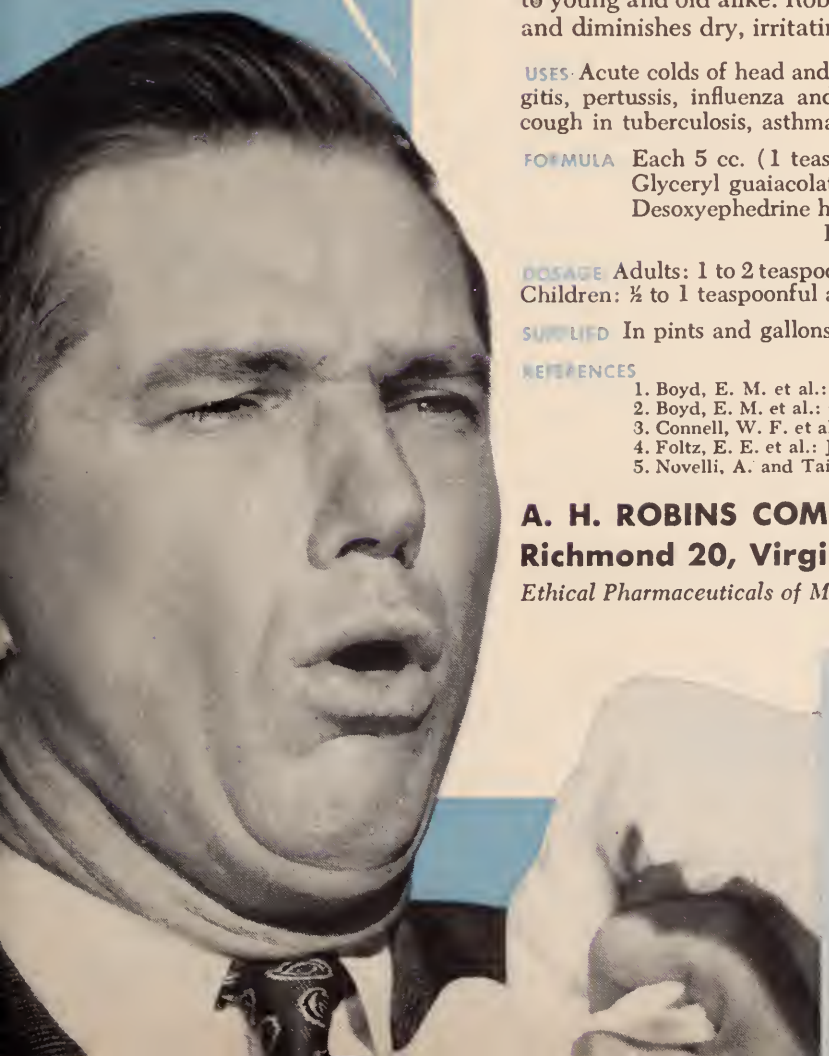
**DOSAGE** Adults: 1 to 2 teaspoonfuls, repeated every 2 to 3 hours as necessary. Children: ½ to 1 teaspoonful according to age, 3 or more times daily.

**SUPPLIED** In pints and gallons.

**REFERENCES**

1. Boyd, E. M. et al.: Canadian J. Res., 23:195, 1945.
2. Boyd, E. M. et al.: Canadian M.A.J., 54:216, 1946.
3. Connell, W. F. et al.: Canadian M.A.J., 42:220, 1940.
4. Foltz, E. E. et al.: J. Lab. & Clin. Med., 28:603, 1943.
5. Novelli, A. and Tainter, M. L.: J. Pharmacol., 77:324, 1943.

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**to facilitate productive cough . . .**
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AT WORK, at home or in your office, penicillin inhalation therapy with the AEROHALOR is as simple and convenient as it is therapeutically effective. Using this handy little device, Krasno et al.[1,2,3] report significant results in a wide range of penicillin-susceptible infections of the respiratory tract. Other reports confirm these observations. • The patient simply inserts a cartridge containing penicillin powder into the Aerohalor and smokes it like a pipe. AEROHALOR's wide mouthpiece and unique tap-sift action contribute to its therapeutic effectiveness. Supplied with a separate nosepiece, the AEROHALOR comes assembled for oral inhalation. • Disposable Aerohalor* Cartridges are prescribed separately in quantity needed. Each contains 100,000 units of finely divided crystalline penicillin G potassium—stable at room temperature. The AEROHALOR and disposable Aerohalor Cartridges are available through prescription pharmacies everywhere.

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**1.** Krasno, L. R., and Rhoads, P. S. (1949), The Inhalation of Penicillin Dust; Its Proper Role in the Management of Respiratory Infections, Amer. Prac., 11:649, July. **2.** Krasno, L., Karp, M., and Rhoads, P. S. (1948), Inhalation of Dust Penicillin, Ann. Int. Med., 28:607, March. **3.** Krasno, L., Karp, M., and Rhoads, P. S. (1948), The Inhalation of Penicillin Dust, J. Amer. Med. Assn., 138:344, October 2.

*Trade Mark for Abbott Sifter Cartridge. Aerohalor and Aerohalor Cartridges patented in U. S. and foreign countries.

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AUREO-MYCIN

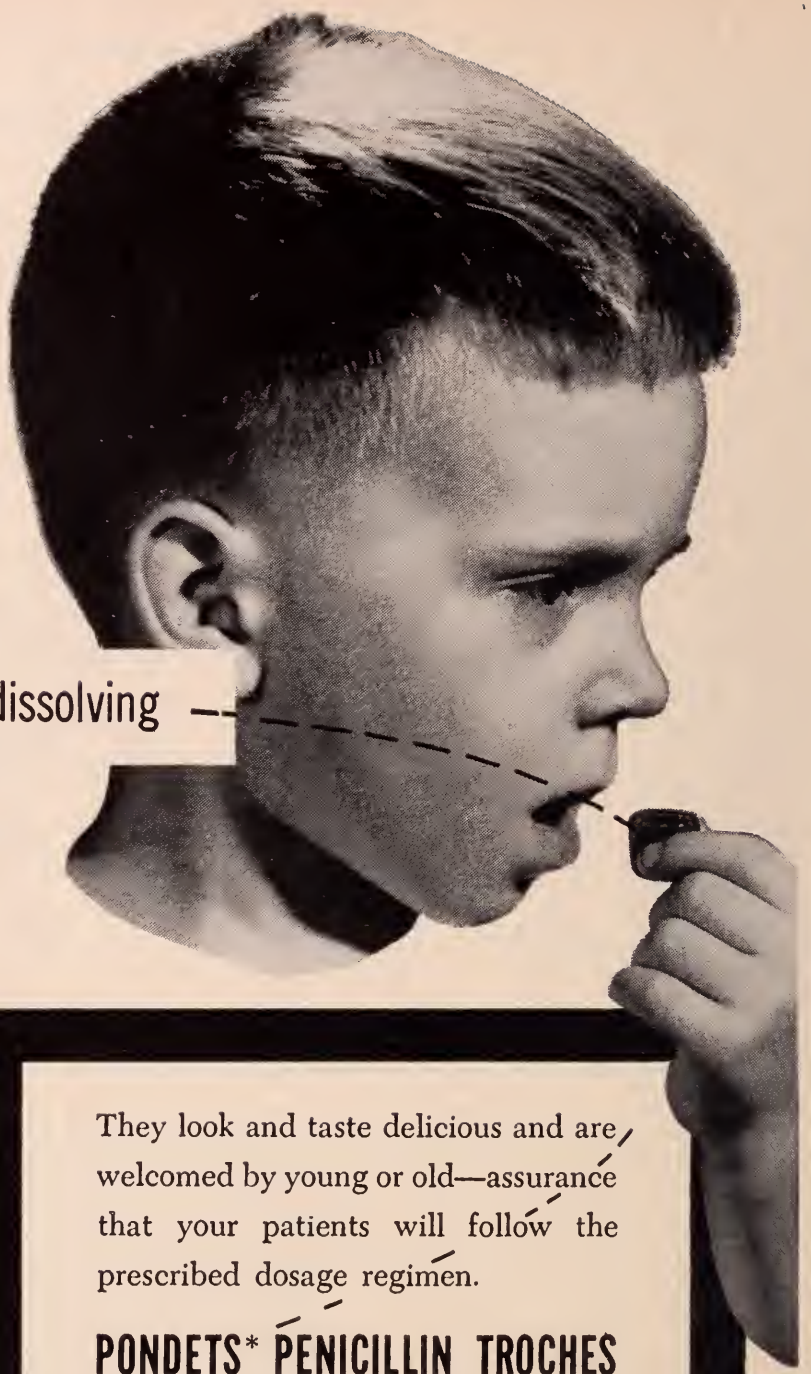
Aureomycin has also been found effective for the control of the following infections: acute amebiasis, bacterial and virus-like infections of the eye, bacteroides septicemia, boutonneuse fever, gonorrhea, Gram-positive infections (including those caused by streptococci, staphylococci, and pneumococci), Gram-negative infections (including those caused by the coli-aerogenes group), granuloma inguinale, *H. influenzae* infections, *Klebsiella pneumoniae* infections, lymphogranuloma venereum, primary atypical pneumonia, psittacosis, puerperal infections, Q fever, rickettsialpox, Rocky Mountain spotted fever, surgical infections, subacute bacterial endocarditis resistant to penicillin, tick-bite fever (African), trachoma, tularemia and typhus.

**Capsules:**
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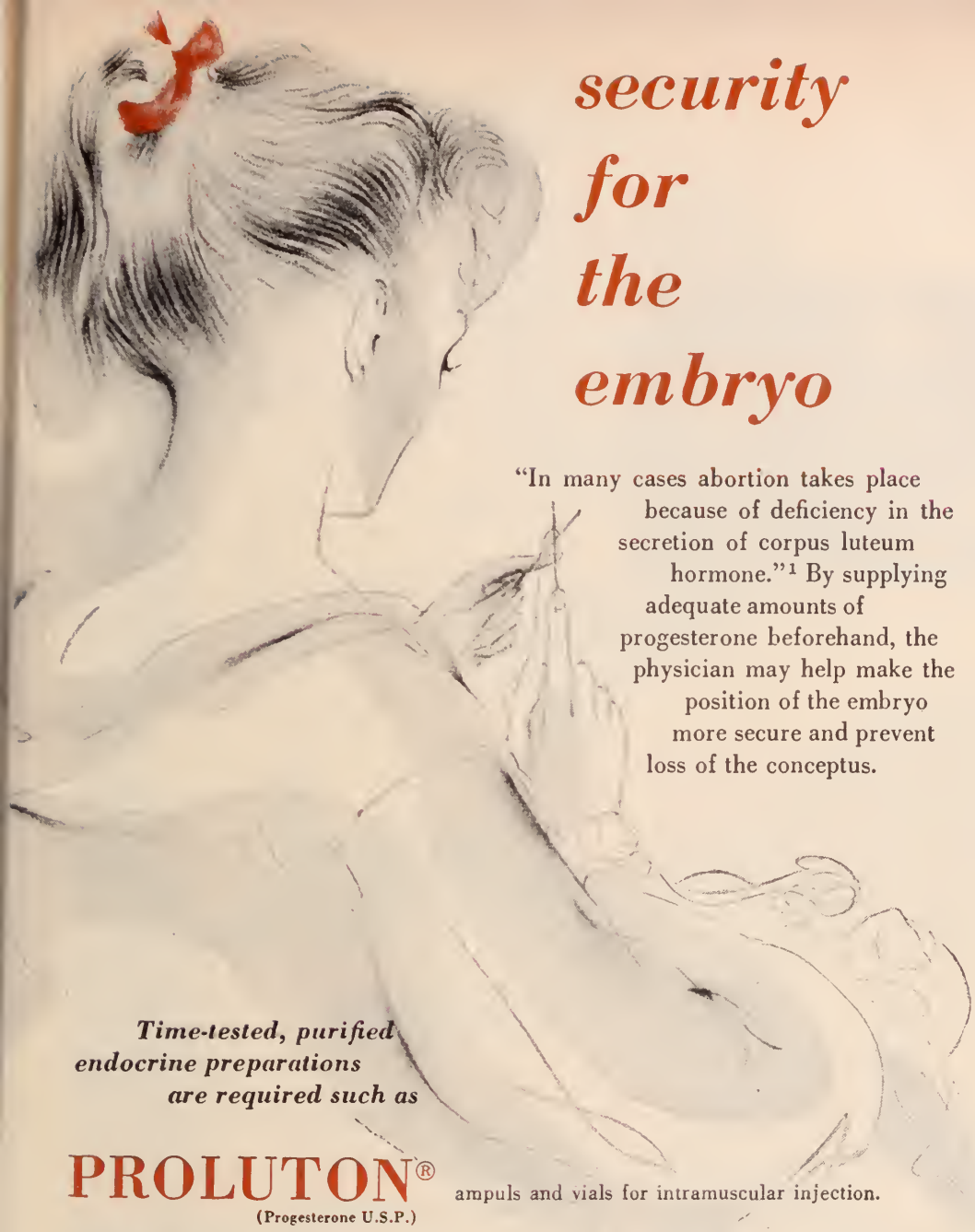
They look and taste delicious and are welcomed by young or old—assurance that your patients will follow the prescribed dosage regimen.

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For local treatment and prophylaxis of oral infections caused by penicillin-sensitive organisms.

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"In many cases abortion takes place because of deficiency in the secretion of corpus luteum hormone."[1] By supplying adequate amounts of progesterone beforehand, the physician may help make the position of the embryo more secure and prevent loss of the conceptus.

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ampuls and vials for intramuscular injection.

**Packaging:** PROLUTON in ampuls of 1, 2, 5 or 10 mg.; in boxes of 3, 6 and 50 ampuls. Multiple dose vials of 10 cc.; 10, 25 or 50 mg. per cc.; boxes of 1 and 6 vials.

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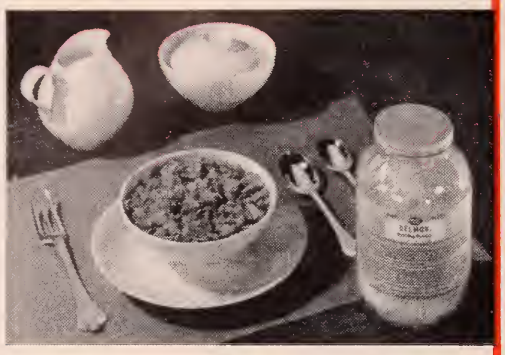
1. Letters, Notes and Answers: Brit. M. J. 2:68, 1945.
*T.M.

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*Delicious!*

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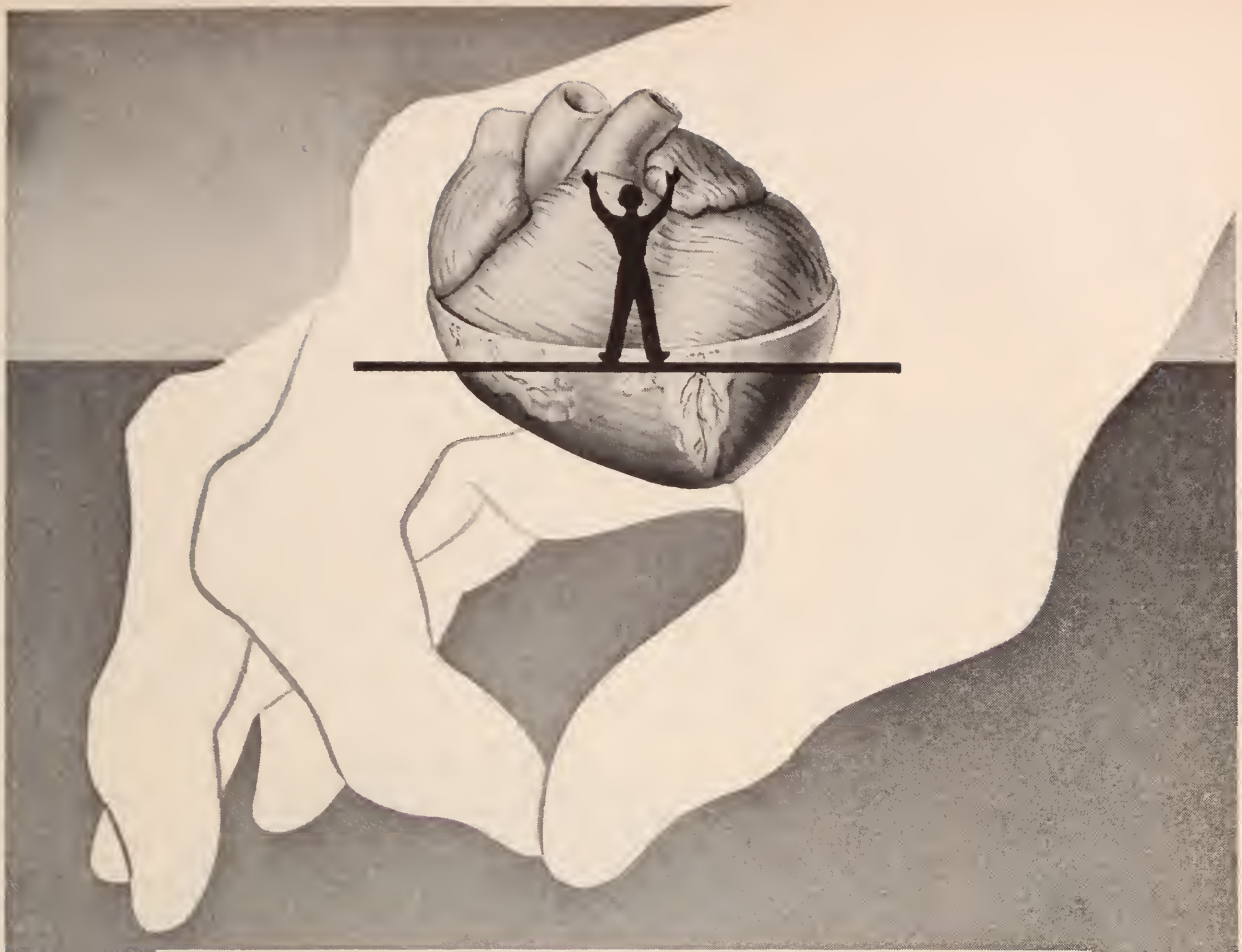
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Each 100 Gm. of DELMOR® contains:

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| PROTEIN | (N x 6.25) derived from milk and soybean . . . 50 Gm. |
| CARBOHYDRATE | derived from cane, milk and grain sugars and soybean 20 Gm. |
| MINERALS | Calcium . . . . . 600 mg.<br>Phosphorus . . . . . 440 mg.<br>Iron . . . . . 15 mg. |
| VITAMINS | Thiamine HCl (vitamin $B_1$) . . . . . 10 mg.<br>Riboflavin (vitamin $B_2$) . . . . . 10 mg.<br>Pyridoxine HCl (vitamin $B_6$) . . . . . 1 mg.<br>Calcium pantothenate . . . . . 5 mg.<br>Niacinamide . . . . . 100 mg.<br>Ascorbic acid (vitamin C) . . . . . 100 mg.<br>Vitamin A . . . . . 4,000 U.S.P. units<br>Vitamin D . . . . . 400 U.S.P. units |
| LIVER | Whole liver substance, together with other natural factors of the vitamin B complex, including vitamin $B_{12}$ 1 Gm. |

DELMOR is a new and exceptionally useful formula for supplementing presurgical, obstetric, or convalescent diets with highest quality whole protein and other essential nutrients. A deliciously flavored powder, DELMOR may be given cooked or uncooked, with any kind of food, or between meals. Supplied in 1-lb. and 5-lb. bottles. Literature and recipes on request. Sharp & Dohme, Philadelphia 1, Pa.



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*Enteric coating allays gastric irritation.*

**As the Sodium Salt.*

**pabasyl**
In Bottles of 100 Tablets.

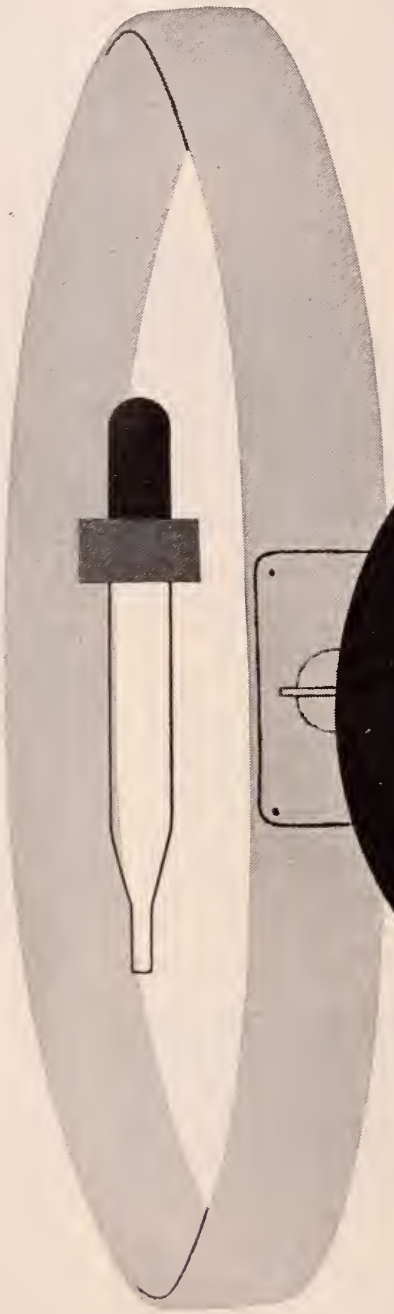
Dosage adult: 2 tablets three times a day.

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*Furlong, T.F., Jr.: Clinical Test of a New Spray, Arch. Otolaryng. 48:658.*
**The Pennsylvania School for the Deaf, Philadelphia*



**POTENT BACTERIOSTASIS** Par-Pen provides the potent antibacterial action of 5000 units of penicillin per cc. . . . plus the vasoconstriction of 'Paredrine' Hydrobromide, 1%.

**DEEP PENETRATION** Penicillin in solution penetrates the tissues more readily than the sulfonamides or tyrothricin, reaching deeply embedded organisms.

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the penicillin-vasoconstrictor for intranasal use

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Nature's effort to repair injury
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Anxieties vanish;
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*A 19" x 12" reproduction of this illustration by Dale Nichols is available upon request.*

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Weather forming above the icy Northern wastes is studied from a network of lonely outposts so that its behavior in distant places may be predicted. In the pharmaceutical industry, the atmosphere not only must be studied but also frequently controlled. Certain materials, such as gelatin for empty capsules, are easily affected by deviations of temperature and moisture. In the laboratories of Eli Lilly and Company, a vast air-conditioning system is operated to control the "weather."

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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 98, No. 6 December, 1950

## ERNEST E. DAVIS — OUTSTANDING GENERAL PRACTITIONER

Dr. Ernest E. Davis of Avon, Illinois has been selected as the outstanding general practitioner for 1951. For a number of months all county society secretaries were informed that they were entitled to submit their candidate and necessary data to the state level by October 15. A secret committee was selected to look over the accumulated data and make their selection, which was done on Sunday, October 22.

Doctor Davis was selected as the outstanding general practitioner for Illinois for the year 1951. He will be the candidate from Illinois to be considered by the A. M. A. Board of Trustees and later by the House of Delegates at the Clinical Session in Cleveland, December 5-8. Doctor Davis is the third to be selected in Illinois as the outstanding general practitioner of the year.

Doctor Davis is a good example of the general practitioner at his best, well rooted in his community, serving it unpretentiously, but with great effectiveness for a full half century. At the same time he keeps himself alert to all that is good of what is new in medicine.

Doctor Davis was born October 29, 1875, in Littleton, Schuyler County, Illinois, 40 miles from Avon, Fulton County, where he has spent the fifty years of his professional career. His father, also a physician, was graduated from Rush Medical School, Chicago, in 1853, and practiced at Littleton until his death in 1888. The son, Ernest, was then 13 years of age, and was determined to follow his father's footsteps in a medical career. His high school education was received in Rushville, after which he attended Northern Indiana Normal School, Valparaiso, Indiana, where he won his B. S. degree.

He then entered Northwestern University Medical School, Chicago, where he was graduated in 1900. He took a competitive examination, and won an internship under Joseph B. De Lee at Lying-In Hospital in Chicago. He located in Avon, then a town of 600, and built up a substantial practice. In his long period of practice in Avon, he has seen it grow to a town of 800, and gradually the development of hard roads, water supply, sewage disposal, and many other things now enjoyed in the smaller towns of Illinois. He contributed much to the growth and development of him home town.

For more than 20 years Doctor Davis served as a member of the school board, and for two terms was president of the village board. He has been a director of their unusually strong State Bank for more than 20 years, and serves as its chairman. He was largely responsible for the development of the Saunders Hospital in Avon some 15 years ago. Although it is operated under his supervision, any ethical physician is permitted to care for his own cases in the

modern, well equipped institution. Approximately 1100 acres of fine land was left as an endowment for the hospital, the income from which pays any deficits in the operation of the hospital. More than 5000 patients have received care in this small hospital, and there have been 1266 deliveries, with only one maternal death, due to a kidney abscess. There have been but six caesarian sections in this series of cases.

Doctor Davis has been especially interested in obstetrics, and his records will compare favorably with the statistics of much larger hospitals anywhere. When he first located in Avon, on account of distance and road conditions, Doctor Davis received permission from the Fulton County Medical Society to become a member of the nearby Knox County Medical Society. He transferred to the Fulton County Medical Society when hard roads made it easier for him to go to Canton, the county seat. For 15 or more years, he has been the delegate from the Fulton County Medical Society to the House of Delegates of the Illinois State Medical Society, and he has functioned well in the many assignments which have been given to him by that Body.

Although his professional work and the Saunders Hospital have been his main interests, Doctor Davis has likewise been interested in farming, and operates a farm of some 600 acres. He has long been known as an outstanding raiser of fine stock, and he spends much of his recreation time on the farms. Doctor Davis has written many scientific papers, which have been presented before state and county medical societies over some period of time. Many of these have been published in medical journals.

In 1906, Doctor Davis married Miss Frances Ross of Avon, and they have four children, Mrs. Lucy A. Larson of Galesburg; Howard Davis of Avon; Mrs. Barbara Janes of Avon, and Giles D. Davis of Milwaukee, Wisconsin. There are five grandchildren, including six year old twins. He has always taken a great interest in his own family, and says it is wonderful to be grandfather to twins.

The loyalty of the entire community to Doctor Davis is and has always been tops, he has been a leader in community endeavors, church work and has really been an important factor in community life. He has long been a member of the staff of the two fine hospitals in Galesburg,



**Ernest E. Davis, M.D.**

and has participated in their respective staff conferences. On several occasions, Doctor Davis has taken post graduate work at Johns Hopkins in Baltimore, the Chidrens Memorial Hospital in Chicago, and at several other places. He spends regularly from one to three weeks each year at some clinical conference or graduate work at one of the Chicago medical schools.

Doctor Davis has been a general practitioner, although he has been especially interested in obstetrics. In addition to his numerous papers on obstetrical subjects, he has likewise presented others on such general subjects, as Scarlet Fever, with a report of 156 cases in 14 months; The Treatment of Burns, Barbital Poisoning, with report of a case; The Therapeutic Control of Peptic Ulcer, and some other subjects.

Doctor Davis, although a practitioner of fifty years, keeps up to date with modern medical achievements, and he does not lessen his activities, and does not look nearly his attained age. He bought his first car in 1914, and has worn out many others since that time. He knew the

rigors of the horse and buggy doctor, and spent many days seeing patients and making the trips on horse back, in a buggy, cart, or a wagon.

The committee which selected Doctor Davis as the outstanding general practitioner of Illinois, with some 15 candidates for the honor, had some difficulty in making their selection, but they were all of the opinion that the first choice was selected wisely and well. They desired, however, to pay their respects to the other fine men whose records were submitted for their consideration, and it was brought closely to their attention that Illinois has many physicians in general practice who will compare favorably in their work and achievements with any in the nation.

Doctor Davis is the candidate from Illinois whose name and records have been submitted to the A.M.A. for serious consideration at the Cleveland Clinical Session.

## WORRIED ABOUT YOUR BLOOD PRESSURE?

"Knowing that I have high blood pressure has poisoned my life." This remark came from a patient of Dr. Robert S. Palmer[1] of Boston who cited it as an example of how some patients feel after they know that they have hypertension. It is an unfortunate attitude but reasonable, considering the stigma attached to the condition. Even physicians who develop the disturbance often find it hard to take.

This is a common occurrence. There are many mysteries associated with hypertension but it is well known that a relationship exists between the emotions and blood pressure. This is taken into consideration when outlining a plan of treatment. To accomplish this aim, the physician often assumes the role of psychiatrist and delves into the personal history and intimate details of the living conditions and habits of the patient. For best results, it often is necessary to uncover and eliminate anxiety, fear, resentment and other disturbing features that might aggravate the pressure.

But there is one cause for anxiety that often is overlooked. This cause frequently stems from the physician himself. It is known as blood pressure anxiety and, in the more suggestive individual, may change a relatively benign hypertension into one that is malignant. It comes from talking too much. During the initial examination of any patient the reading is likely to be elevated due to excitement and apprehension. All too often it is normal by the next visit provided the reading was not excessive originally. Many feel that it is unfair to bring the height of the blood pressure to the attention of the patient during the initial consultation. Furthermore, this is no time to order extensive laboratory procedures; it is better to wait until a definite diagnosis of hypertension has been made. This is avoided by not mentioning the blood pressure until the second or third visit. In this way, blood pressure anxiety does not complicate the picture.

If the new research on blood pressure by Master, Dublin, and Marks[2] is accepted, it will help to avoid trouble along this line. These men believe that our present standards are too low and in this respect share the opinion of many physicians. All of us have seen many men and women with hypertension live far beyond normal life expectancy. In addition, the authors noted that: "Blood pressures of 140 mm. (of mercury) systolic and 90 mm. diastolic or over are present in about 40 per cent of both men and women at ages 45 to 49 and in 60 per cent at ages 60 to 64." . . . . "Even on the basis of a dividing line of 150 mm. systolic and 100 mm. diastolic, the prevalence of hypertension was high. It was estimated that 32 per cent of the men aged 40 and over had this degree of hypertension; at 50 and over, 43 per cent; at 60 and over, 55 per cent, and at 70 and over, 62 per cent. The percentages for women in these age groups were substantially higher than those for men."

They reevaluated the data by means of a more logical statistical analysis. The results showed that higher readings were within normal limits. The normal range, for example, of systolic blood pressure in males starts at age 16 with 105 to 135 mm. and progresses so that at ages 60 to 64, it is between 115 and 170 mm. An excerpt from their comment near the end of the article is worth repeating: "Since systolic pressures of 160 to 190 mm. of mercury and diastolic pressures of 100 to 110 mm. of mercury are not

1. Palmer, Robert Sterling: Psyche and Blood Pressure, J.A.M.A., Vol. 144, p. 295, Sept. 23, 1950.

2. Master, Arthur M., Dublin, Louis I., and Marks, Herbert H., The Normal Blood Pressure Range and Its Clinical Implications, J.A.M.A., Vol. 143, p. 1464, Aug. 26, 1950.

uncommonly observed after the age of 50, patients with such readings may be in good health, and efforts to lower the blood pressure by means of drugs or strict low sodium or rice diets may be unnecessary. In evaluating the status of these patients, one should first determine cardiac function. If coronary disease, cardiac enlargement or heart failure are present, therapy should be directed toward these conditions rather than toward hypertension." These findings should be reviewed by all physicians who wish to change their concepts of hypo and hypertension.

## "TAKE AS DIRECTED"

**Noble J. Puffer,**
**Director, Department of Registration and Education**

I have been officially informed that a large number of doctors are submitting prescriptions which are to be filled by pharmacists with only the instructions, "Take as directed."

The instructions, "Take as directed" should be avoided. An ill patient or a distracted and worried parent or relative cannot always be relied upon to remember clearly the verbal directions given by the physician, or he may remember them incorrectly. If the directions are too lengthy or complicated to be placed on the prescription, they may be written on a separate instruction sheet and left with the patient. Directions which would be embarrassing to the patient if placed on the prescription should be given in private.

Detailed directions to the patient may be omitted from the signature in the case of prescription for vaginal or urethral application, etc., that is, when the directions would be of such a nature that their presence on the label would unnecessarily offend the modesty of the patient.

Under these conditions it is customary to order the prescription to be used, "As directed." When such is done, the physician should give the detailed directions for the use of the prescription to the patient in writing, and if the prescription is one that would be poisonous or otherwise dangerous if taken internally, he should direct it to be labeled, "For external use only" or should order a poison label to be placed upon the container. In this class of prescriptions, it is often advisable to omit the patient's name from the prescription for the same reason that calls for the ommission of the detailed directions for use.

The signature comprises the necessary directions to the patient for his use of the preparation. These directions should include the size of the dose, the frequency of its repetition, the necessity for its dilution or other modifications, and such other information as may be needed to guide the patient in its safe and proper use.

Since we are all concerned about the health of the patients, I would urge every physician to read this article carefully and even if it takes a few seconds more to prepare the instructions on the prescription, it is, I believe, a necessary step. I have taken this means of calling the problem to your attention since I have no direct method of communication with the medical profession except through their own periodicals.

## VULVAR SORES

It is felt that granuloma inguinale offers a very hopeful prognosis if diagnosis is made early and modern antibiotic therapy is employed. In the recurrent or neglected case, where distortion of the external genitalia has become a serious problem to the patient, surgery (vulvectomy) in addition to antibiotic therapy (streptomycin) will give successful results. Other venereal diseases should be excluded by appropriate tests and treated if present. Biopsy will eliminate possibility of carcinoma which should always be considered in the differential diagnosis. *Excerpt: Granuloma Inguinale Treated by Vulvectomy and Streptomycin, Mary DeWitt Petitt, M.D., F.A.C.S., professor of gynecology, and Carmen C. Thomas, M.D., Sc.D., professor of dermatology, Woman's Medical College of Pennsylvania, J.A.M.W.A., Sept.,* 1950.

# MEDICAL ECONOMICS

**The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Maloney, Roland R. Cross, Alfred P. Bay, Frederick T. Jung.**



## Why We Study Medicine

A large number of students applied for admission to the 1950-1951 freshman class of the University of Illinois College of Medicine. Of these, 544 fulfill the scholastic requirements for entrance. In this group are 248 veterans. From these 544 candidates only 166 can be selected, for that is the capacity of the incoming freshman class. Included in the accepted number are 67 veterans. In choosing the successful one-third of the applicants, four main factors are considered:

1. The grade point average for the three or more pre-medical college years.
2. Written recommendations from four college teachers.
3. Interviews by two or more members of the Interviewing Committee for Admissions of the College of Medicine.
4. Results of the "Medical College Admissions Test" commonly called the "Aptitude Test."

Selection often is difficult because there are many extenuating circumstances. Every effort is made to be entirely impersonal and impartial and to judge each applicant on his or her own merits under the four categories listed.

The following analysis included 509 (27 women) applicants, all of the records that were in the files when the study was made. 166 were admitted and 343 deferred. Of 482 men, 160 were accepted—33%; of 27 women, 6 were accepted—22%. The fathers of 40 of the applicants are physicians. Of these, 14 are accepted and 26 deferred. This is almost exactly the same ratio that the total number of accepted bears to the total number of applications analyzed. In other words, 32.6% of the total applicants are accepted and 35% of the physicians' sons are accepted.

### ANALYSIS OF 166 ACCEPTED APPLICANTS

Eighty-three (79 men, 4 women) are from Cook County, eighty-three (81 men, 2 women) are from counties other than Cook in Illinois. Sixty-seven are veterans of World War II. Ages vary from 19 years to 34 years; the greatest number are in the 20 year group. The distribution is: 19 years—11, 20 years—55, 21 years—28, 22 years—18, 23 years—16, 24 years—13, 25 years—11, 26 years—1, 27 years—3, 28 years—3, 29 years—4, while one was 30, one 32 and one 34 years.

One applicant was born in Germany, another in Austria. One was born in the Belgin Congo of American missionary parents. There are two Negroes in the class. One applicant is a rabbi,

two are graduates of the Naval Academy, one is a descendant of William and John Hunter, one received the Bausch and Lomb award for scientific work.

Naming the birth places of the parents is not required on the applications but often they are noted. The following were found in the records: six fathers born in Russia, two in Germany, three in Poland, one in Lithuania. Of the mothers, one was born in Russia, one in Czechoslovakia, and one in Lithuania. This is a very incomplete record. Interviewing applicants for many years, the writer has been impressed by the high percentage of first generation Americans who desire to study medicine. This fact should be emphasized, not hidden, since it is a tribute to our new citizens and to our country, the speed with which they take advantage of our free educational system.

It is not required to state the occupations of the parents but often they are noted on the application blanks. Many applicants seem proud of the accomplishments of their parents. As stated before fourteen applicants are sons of medical men, while the mother of one is a physician. Sixteen others have brothers, uncles, aunts, grandfathers or cousins who are physicians. Three fathers are dentists, six are ministers, one is a druggist, on a veterinarian, one father is an Annapolis graduate, one brother is a minister. Mention is made of two mothers who are nurses and one a social worker. Fathers of 12 applicants are dead and they have been supported entirely or in part by their mothers. Several said: "My mother thinks so much of her doctor that I want to become a physician."

*Plans For the Future.*—Of the 166 applicants who will enter medical college, 26 have no plans beyond the acquisition of an M.D. They feel there is ample time during the medical course to decide whether or not to specialize, the type of specialty, the most advantageous location and other questions pertaining to the future. Many others are quite undecided, perhaps it will be "surgery" or maybe "obstetrics" or even "general practice." It seems evident that "general practice" and "internal medicine" are used synonymously on a number of applications.

By contrast, others have definite plans. One will suffer thru medical college to become a brain surgeon, another desires to do nothing but surgery of the hand. Eighty-three (27 from Cook County) desire general practice at least for the first five years. Forty-eight (12 from Cook County) wish to practice in small towns or rural areas. Only two mention Chicago especially as the site of their choice for practice. Several say they want to be near a large hospital, a medical college, dependable laboratories and reliable consultants without giving specific locations.

The following specialties are mentioned: surgery, 17 times; psychiatry, 16; research, 14; mission field, 9; pediatrics, 9; neurology, 5; while cardiology, obstetrics, gynecology, roentgenology and teaching each are listed four times. Orthopedics receives three votes while ophthalmology, anesthesiology, and tropical medicine obtain two each. The following specialties are noted once: otolaryngology, electronics, pathology, proctology, brain surgery, public health and endocrinology. A few applicants list a number of possible specialties, only the first three choices are considered in this analysis. Several mention research as a last resort or as something to return to after years of successful practice. A number of applicants state "any plans I have now are subject to change while I am in medical college."

Here are a few quotations concerning specialties: "I have ideas and plans which I believe will be of great benefit to those who are in need of accurate diagnosis and treatment. My particular interest lies in x-ray. I contemplate to treat people of low and middle brackets so that they might be able to receive excellent work at a cost within their budget. Also a laboratory, open 24 hours, and to do research." "I want to specialize in surgery. I have carved figures out of wood and built model airplanes." "I am ready to devote myself to my work. If I could donate my right arm and still become a surgeon I would do so."

*Reasons For Studying Medicine.*—About 70 applicants list more than one reason: Desire to help his less fortunate brothers, to better the world, to conquer disease, and to decrease suffering are listed more often than other reasons. These altruistic, humanitarian desires are noted 53 times. Here are some exact quotations on the subject: "Medicine to me is far more than a mere occupation. It is a life devoted to the service of mankind." "My foremost efforts will be put forth to free humanity from the discomforts and pains that now plague it." "I use the analogy

of the truck with the human body. If I could get broken down trucks to run again, how much more wonderful it will be to repair and make healthy the broken down human body." "Medicine is the most interesting, dynamic and purposeful of occupations devoted to alleviation of suffering or perpetuation of the life of a fellow human. I have always revelled in matters of complexity and magnitude."

Interest in science, chiefly biology, in high school and college served as an inspiration 42 times. Twenty-seven could list no specific reason. They simply knew they have wanted to be doctors and have had that desire since early childhood. Here are some general quotations: "The greater the problem the greater the feeling of victory." "The medical field with its unlimited horizon of science and its wealth of personal contacts will afford the most fertile field for developing my potentialities and interests." "The medical profession to me is the culmination of everything one has learned or been taught." "A doctor seems to have most contacts with people. He is first to greet an infant and in a short time is accepted and admired by the youngsters whose admiration grows as he grows and is passed on to his children. A doctor knows no age group."

Twenty-eight were inspired by specific contacts with people such as the family doctor, father or near relative who is a physician, mother a nurse or social service worker. One "dated a medical technician" and was stimulated by her hospital stories, another was inspired by reading books by Paul De Kruiff, while another desires to follow Albert Schweitzer. One wishes to emulate his father-in-law who is a physician. Fourteen began thinking of medicine as careers while serving in the army and five while in the navy. Thirteen conceived the idea because of personal illness or the suffering of mother, father or chum. Several expressed it this way: "I feel an overpowering desire to enter the profession and I was highly motivated by some surgical and hospital contacts when I had a pilonidal cyst removed." "I first became interested in the medical profession approximately six years ago when I successfully cured a rash on a horse's head."

Twelve applicants wish to practice medicine to make money and to enjoy the security the profession affords and eight covet the prestige which physicians enjoy. Some say it in this fashion: "It is my desire to be in a profession, highly valued, respected and honored by the multitude." "The very title 'Doctor' has an appeal because it is a position of respect and a challenge to obtain." "The doctor is a respected man with an infallible character, scrupulous morals, and high ideals." "An M.D. has security, happiness and contributes to society." "I don't pretend to disdain the good income which most physicians earn." "I shall be proud, respected and financially secure and no one will be giving me orders."

Ten plan medicine as a career for religious reasons. Written in these words: "God has called me to study medicine." "God told me to go to India as a medical missionary." "Life to me is a fascinating challenge, ultimately understood only by God." "To restore health and happiness." "The ultimate end of all learning should be the good it can do for mankind."

Six are curious to know how the human body ticks. Stated in this manner: "What strange and wonderful secrets the human body conceals." "The essential nature of medicine provides the keystone for such a global orientation to the organism and I feel mature enough to concentrate my efforts in this direction." "Health, disease and death have always been problems to me." "Medicine integrates in its extention the fields of biology, chemistry and psychiatry. It is this apex of integration in medicine at which my drive 'to know' is found." Three believe they would derive personal satisfaction from the practice of medicine.

Three developed the urge for medicine because they were boy scouts and three others while taking courses in first aid and another during his counselorship at a boys' camp. The interest of two were aroused by the gifts of chemical sets when they were little boys. Two entered medicine through physical education. One was inspired by a tour through a medical school.

One applicant seeks intellectual stimulation. Another is dissatisfied with theology and hopes to find gratification in medicine. One wishes to be his own boss. Another was stimulated while working in a funeral home. Employment in a drug store was inspiration to another. One boy read a "history of medicine" at the age of nine years and decided to become a doctor. Another

wishes to study medicine because his town deserves a good doctor—two physicians live in his town; one is a morphine addict, the other partakes too freely of alcohol.

The reasons for studying medicine sometimes are listed in a few short sentences, sometimes in several pages of flowery language. These applicants know it is difficult to enter medical college. This fact undoubtedly influences the reasons listed. It would not be human to ignore the imagined ideas and ideals of the admissions' committee. Some list several personal reasons and end with the after thought of "aiding mankind." On the whole, the motives have a definite ring of sincerity.

ANALYSIS OF 343 DEFERRED APPLICANTS

Three hundred forty-three applicants, 322 men, 21 women, fulfill the requirements for admission but could not be accepted for lack of facilities. Two hundred twenty of these are from Cook County, one hundred six are from Illinois outside Cook County, seventeen are not residents of the State. Four non-residents are from California, three from New York, two from Pennsylvania, and one each from Kentucky, Ohio, Connecticut, Colorado and Arizona. Three are from foreign countries: Borneo, British Honduras and Nigeria.

Ages vary from 18 to 43 years. The largest numbers fall into the 21 to 22 year brackets. One hundred twenty-five desire to enter general practice, seventy-two have no definite plans, eighty hope to practice in towns or in rural Illinois, seven wish to practice in Chicago. One plans to go to each of the following countries as missionaries: French Equatorial Africa, Alaska, China and the Sudan.

*Plans for Specialties.*—Surgery heads the list with 38, psychiatry is next with 34 and research 31. All of the specialties listed under the "accepted group" are represented plus parasitology, industrial surgery, dermatology, cancer research of the skin, allergy, preventive medicine, urology, hematology, gastroenterology, research on poliomyelitis, oral surgery and research in bacteriology.

Eight applicants were born in other countries: Germany 2, one each from Borneo, Philippines, Nigeria, Poland, Mexico and Italy. Foreign born parents were mentioned 104 times (73 fathers, 51 mothers). This is a very incomplete statement for many of the applications did not contain this information. Four are Negroes, sixteen are married. Fathers of 27 applicants are deceased.

Reasons for studying medicine fall into the same general groups as those of the accepted students with the following additions: "To benefit my race." "Death of parents." One stated the first composition written in primary school was entitled "I Want to be a Doctor." One operated on snakes and mice. A broken leg served as an introduction to another. Seeing an epileptic convulsion aroused another. Dissatisfaction with Chiropody stimulated desire for greater knowledge. Reading "Layman's Handbook of Medicine." "My father is a Chaplain at a hospital. Visits with him stimulated by interest in medicine." Two have wives who are studying medicine. One was inspired by reading the "Life of Harvey Cushing." Employment as a social worker decided one applicant. Psychoanalysis for mental illness aroused the desire of one to become a psychiatrist. When one applicant was 9 years old, his father gave him five volumes on physiology and anatomy. He read them avidly and decided to study medicine. Work in "Poisonous Animal Research" served as an inspiration. An embalmer became interested in anatomy and pathology. Cholera epidemic in China, 1935, initiated interest of another in medicine.

Here are some quotations from applications. This statement must have come from a rather frank fellow: "I won't waste paper by enumerating the usual supercilious reasons put forth. I have no altruistic designs but desire to become a physician because it is the best means of livelihood I know." Personal aims are listed only a few times but here are some: "Personal growth, self-respect and self-esteem—as an authority on the human race—life and health." "The doctor's merit alone can earn for him an admirable reputation and the respect of his community." "Professional associations of highest quality and character in clean, pleasant surroundings." "Because I feel I have a way with people and am a person in whom people would want to place confidence."

Here are some quotations which differ from the general group: "Interest seemed to arise spontaneously within me." "Desire to raise myself to a professional, social level." "It is a profession of sacrifice but of rewards." "Medicine offers a scope and knowledge that is not only

informative but also conducive to thought, meditation and further research." "My plan to study medicine is for the purpose of becoming a psychoanalyst. I hope to go to medical school in Chicago to be near the Institute for Psychoanalysis." "Medical profession is among the most honorable and it stands out above the others because it has to do with the most wonderful of mysteries—human life." "Dr. ———, my inspiration and ideal, is dead but my only hope and prayer is that some day I will be as wonderful a doctor as he was." "At the age of 15, I witnessed the birth of a child upon the steps of Mother Cabrini Hospital. That sight so impressed me that since I have had no other ambition than to become an obstetrician."

To quote further: "The qualification for Life's occupation is constant acquisition of knowledge, consequently wisdom, helping the community by relieving individual worries and sickness and social contacts through patients, prestige, and economic security." "Motivated by keen desire to make a contribution to the welfare of mankind and fortified with the knowledge and belief that I possess the personal equipment to fulfill that desire has brought me to the conclusion that I am adapted and suited to practice medicine." "Interest in medicine began when I carried out my task of fish cleaning, rabbit and pheasant dressing and drawing of domestic fowl." "When cholera swept South China in 1935, thousands of people died from ignorance and inadequate medical care." "Medicine to me is more than a profession, it is a way of life. Medicine is the most fascinating field of endeavor pursued by man." "I realize my choice involves some hardships but the personal satisfaction more than compensates for any sacrifice I may have to make."

Many expressed their choice of medicine as a career on a high humanitarian note: "To live in this world and be happy one must serve mankind, in some way. It is through this cultured medium, the medical profession, that I wish to offer my contribution to mankind." "During my childhood the family doctor created in me an impression of awe inspiring respect. He was the witch doctor who could perform miracles in returning one from sickness to health."

Some are very personal: "My gluteus maximus still smarts when I think of the time my mother found me dissecting a snake on her breadboard, trying to find out how it could crawl so fast without any legs to do it with." "My mother and several of her sisters are nurses. As I listened to them talk about doctors and hospital life, I acquired a keen interest in the medical profession." "The medical and spiritual penury of the women of India was presented to me. The Lord led me shortly after this to study to be a missionary doctor to the women of India." "I feel a debt to myself and to my father's patients and to my father whose death at the age of 46 may be directly attributed to overwork in the practice of the profession which he believed and I believe to be the only means of profitably spending one's life."

Comparison of the accepted group with the deferred group reveals few differences so far as their inspirations and aspirations for the medical profession are concerned. The vast majority state a preference for small town or rural practice. This decision may be colored by the fact, so often emphasized, the need for doctors outside the large cities.

Under "Reasons for Studying Medicine" each statement is interesting but only a few are quoted. One is impressed by the small instances which change the life plans of people, the receiving of a chemistry set when a child, the casual reading of a book, conversation with one person on a single occasion, personal illness or contact with the illness of others. Teachers of biology in high school must present their subjects well, for many applicants mention this first contact with science as their earliest stimulae for the choice of medicine as a career.

The big question is "What will become of all these qualified but deferred applicants who have spent several years in preparation and more years in planning and dreaming?" The disappointment to them and to their families is great. Some will reapply next year. Even now some applications have been renewed annually for 3 or 4 times. Of course, preparation for medical college will serve also for other careers. Some may become dentists or teachers. Others will enter research. Chemistry, especially industrial chemistry, is an expanding field. Commercial work in the pharmaceutical houses, and laboratories are profitable outlets. Although these young people may make satisfactory adjustments to life, they will always remember, and on many occasions will say—"I planned to study medicine, but—!"

# CORRESPONDENCE



## "YOUR MENTAL HOSPITALS" — RESEARCH GRANTS

The Illinois Department of Public Welfare, through its various state hospitals, has been able to foster research in various aspects of mental illness in order to improve the care of the mentally ill. At the present time research grants have been made available to several of the institutions.

At the Elgin State Hospital, Elgin, Illinois, a $10,000.00 grant has been made available by the Vitamin Foundation to assist in the work being conducted on studies of niacin and tryptophane requirements and interrelationships in human nutrition. Investigations at the Elgin State Hospital have uncovered evidence that the psychiatric behavior of the mentally infirm is aggravated if inadequate amounts of vitamin B are present in the diet. Previous investigations showed conclusively that ill effects on mental health could result from inadequate allowances of B complex vitamins. In the early studies, a biochemical procedure was devised to recognize the earliest stages of vitamin B deficiency. Results of this research suggests that the aged are less resistant than the young to the ill effects of low vitamin B diet. The success of this project has led to the furthering of research on similar projects on the human requirements of other aspects of the vitamin B complexes.

At the Lincoln State School and Colony, Lincoln, Illinois, a federal grant of $2500.00 was allocated for the purpose of research to help in devising psychological tests for testing and diagnosing physically handicapped children. The grant is to be used for the standardization of the Oseretsky Tests of motor proficiency. When these tests are standardized, they are expected to provide a scale for measuring an individual's motor proficiency at different levels of development, and these tests should also aid in the more complete diagnosis of a person's total capacities. It is hoped that valuable information in physically handicapped, as well as normal children, can be otbained. The tests might provide a method for estimating the degree of motor defects in various types of cerebral palsy.

At the Elgin State Hospital, a grant of $4,800.00 was recently received from the United States Public Health Service to carry out certain research projects in the field of psychology. The two projects are:

(1) The development and standardization of projective techniques for psychiatric aides.
(2) The study of prodromal factors in mental illness.

In the first study, various psychological tests are to be used in an attempt to set up scales for the selection and evaluation of psychiatric aides. At the present time, these tests are simply used

as research tools. If it is found that some of these techniques give significant results in differentiating individuals who prove to be highly efficient psychiatric aides from those who are not satisfactory, then a significant advance will be made.

In the second study, attempts will be made to get objective evaluation and diagnostic and prognostic significance in prodromal factors in mental illness, including such important factors as pre-psychotic personality, early home and school adjustments, onset and duration of psychotic symptomatology, etc.

Thus the Illinois Department of Public Welfare is constantly striving, through various methods, to improve the care of the mentally ill in the mental hospitals of the State of Illinois.

George A. Wiltrakis, M.D.
Deputy Director

## FIFTH CONGRESS OF PAN-PACIFIC SURGICAL ASS'N.

The Fifth Congress of the Pan-Pacific Surgical Association will be held in Honolulu *November* 10-21, 1951.

The object of the Pan-Pacific Surgical Association is to bring together surgeons from countries bordering on the Pacific Ocean so as to permit the exchange of surgical ideas and methods and to develop a spirit of good fellowship among the various races represented. Although it was planned that meetings would be held every three years, world events have permitted but four conferences since the organization was conceived—the first in 1929 and the last in 1948.

The Fifth Congress provides an opportunity for doctors to combine a delightful vacation in Hawaii with attendance at a scientific meeting, the program of which will be presented by top-flight surgeons from the Pacific area countries, as planned by the program committee. Doctors are urged to bring their families with them and are promised luxurious accommodations.

Dr. F. J. Pinkerton, President of the association, has been officially appointed as travel agent for those coming to the meeting. To be assured of preferred accommodations, travel and hotel reservations should be made through Dr. Pinkerton.

Further information may be obtained by writing the Pan-Pacific Surgical Association office, Suite 7, Young Building, Honolulu, T. H.

## REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

*A competitive examination* for appointment of Medical Officers in the Regular Corps of the United States Public Health Service will be held on February 12, 13, and 14, 1951. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than January* 15, 1950.

*The Regular Corps* is a commissioned officer corps composed of members of various medical and scientific professions, appointed in appropriate categories such as medicine, dentistry, nursing, engineering, pharmacy, etc.

*Appointments will be made* in the grades of Assistant Surgeon (equivalent to Navy rank of Lieutenant (j.g.) and Senior Assistant Surgeon (equivalent to Lieutenant). In making assignments, consideration is given to the officer's preference, ability, and experience; however, all commissioned officers are subject to change of station and assignment as necessitated by the needs of the Service. Appointments are permanent in nature and provide opportunities to qualified physicians for a life career in clinical medicine, research, and public health. Applicant who successfully complete this examination may ordinarily expect appointment as soon as they become eligible.

*Requirements; Both grades*: United States citizenship. At least 21 years of age. Graduation from a recognized school of medicine.

*Assistant Surgeon*: At least seven years of educational training and professional experience subsequent to high school.

*Senior Assistant Surgeon*: At least ten years of educational training and professional experience subsequent to high school.

Applicants who will complete these requirements within nine months of the date of the written examination will be admitted, but may not be appointed until they meet the above requirements. Physicians who are successful in the examination and are now serving internships will not be placed on active duty in the Regular Corps until completion of internship. The examination will include an oral interview, physi-

cal examination, and written objective tests covering the professional field.

*The written professional examination* for the grade of Assistant Surgeon will cover the following material: basic medical sciences, including anatomy, physiology, biochemistry, microbiology, and pathology; practice of medicine, in- and psychiatry), therapeutics and toxicology, cluding internal medicine (including neurology pediatrics, and medical problems of obstetrics and gynecology; practice of surgery, including surgery, orthopedics, gynecology, obstetrical procedures; and preventive medicine and public health. The examination for Senior Assistant Surgeon will include the above subjects with the exception of anatomy.

*Physical Requirements*: Candidates must be found physically qualified as a result of an examination performed at a Public Health Service facility. Since the physical standards for appointment to the Commissioned Corps are relatively high, it is recommeneded that applicants complete this examination as soon as possible to obviate the necessity of taking the written examination if found not physically qualified. Candidates who are examined before January 2, 1951, can probably be informed of their eligibility or failure to qualify before the written test. Candidates who have a physical defect, or who have had serious illness or injury, should attach a statement to their applications outlining in detail the nature of such illnesses or injuries, treatment received, periods of hospitalization, length of absence from work, and present status.

*Gross pay* is identical to that of officers of equivalent rank in the Army and Navy. Entrance pay for an Assistant Surgeon with dependents is $5,686.56 per annum; for Senior Assistant Surgeon with dependents, $6,546. These figures include the $1,200 annual additional pay received by Medical Officers as well as subsistence and rental allowance. Officers on active duty are not eligible to receive disability compensation from the Veterans Administration.

*Promotions*: Provisions are made for promotion at regular intervals up to and including the grade of Senior Surgeon (Commander) and for promotion by selection to the grade of Medical Director (Captain).

*Retirement pay* after 30 years of service or at the age of 61 is three-fourths of annual basic pay at the time of retirement. Retirement for disability is authorized under the Career Compensation Act, and minimum disability retirement pay is ordinarily one-half of annual basic pay at the time of retirement.

*Additional benefits* include periodic pay increases (time served as a member of the armed forces is credited), 30 days annual leave, sick leave, full medical care, and the usual privileges extended to officers of the military forces.

*Application forms* and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

*Applications received after January 15, 1951, can not be accepted.*

## ANNUAL PRIZE

The Chicago Society of Industrial Medicine and Surgery awards an annual prize of $150.00 for a meritorius scientific paper in the field of Industrial Medicine and Surgery.

The purposes of this contest are: 1. To stimulate original thinking among the younger group who are to be eligible. 2. To encourage publication of worthwhile studies and procedures. 3. By direction of thinking toward industrial health problems, to attract desirable graduates into the field of Industrial Medicine and Surgery.

Eligibility and Judging: Any physician in the Chicago area who has received his M.D. degree within the six years immediately prior to the date closing the contest (March 1st) for the current year shall be eligible. Three judges will be selected, one from each of two medical school faculties, and one from the membership of our Society. The judges shall have the authority to withold the award if a paper of sufficient merit has not been submitted.

Subject matter: The paper must present original laboratory or clinical ideas or research data pertaining to industrial medical or surgical subjects. Papers will be judged on originality, prospective or proven value of application in practice, and clarity of presentation. It shall not have been previously published or presented at a meeting. Subsequent to the award, the author will publish the paper in a suitable scientific journal with an attached notation of the award. The manuscript with two carbon

copies submitted for the contest should not be signed by the author, but should be identified by detached letter and mailed to the secretary of the Society, who will then identify each by number and forward to the judges. The manuscript shall be submitted not later than March 1st each year. The paper and award will be presented at the annual meeting of the Society.

BURTON C. KILBOURNE, M.D.
Chairman-Committee on Awards
CARLO SCUDERI, M.D.
President

## WOMEN'S AUXILIARY SHOULD ASSIST "MARCH OF DIMES"

The National Foundation for Infantile Paralysis is now facing the most acute period in its history and all Chapters in the State of Illinois are realizing the situation is definitely critical.

The severe epidemics in Illinois lasting from 1945 through the present year have thrown a real burden on the 102 NFIP County Chapters. Last year's severe epidemic left many seriously paralyzed patients who are still receiving medical care, both in and out of hospitals. The financial burden on the Illinois chapters has been the greatest in the history of their organization.

It has been necessary for most of the Chapters in Illinois through this five year period to lean heavily upon epidemic aid funds from national headquarters. Inasmuch as the only means of revenue these chapters have is the March of Dimes, it is hoped that the coming drive will provide sufficient funds to carry on the important three fold program of medical care, research and education.

Allied with the Foundation in their vigilance to protect children's welfare the Women's Auxiliary to the Illinois State Medical Society has a unique opportunity to take the lead in the 1951 Campaign. Auxiliaries may actively assist the MARCH OF DIMES by supporting the Drive in their communities, and by adopting the campaign as a Public Service project for January. Individual members may also provide valuable help in publicity, solicitation, special events and other critically needed services by contacting their County Chapter of the Foundation immediately.

## ANNUAL CLINICAL CONFERENCE

The Clinical Conference of the Chicago Medical Society is designed to bring physicians new resources to meet their problems in everyday practice. A faculty of thirty-four outstanding speakers will present half-hour lectures and another group of authorities will participate in the four Panels on timely topics.

Each year the Society presents something new which will be of interest to those attending. The special feature for the 1951 Conference will be daily teaching demonstration periods from 11:00 to 12:00 noon and 1:30 to 3:00 P.M. These will include demonstrations of Amputations and Prostheses, Patients Treated with ACTH and Cortisone, Dermatologic Clinic, Proper Application of Casts and Splints in Fractures, Fluid and Electrolytic Balance in Surgery, Local Anesthesia, Use and Misuse of Obstetrical Forceps, Organization of a Blood Bank, Neurological Clinic, Sterility tests, Common Problems in X-Ray Interpretations, Laboratory Tests including tests for Diabetes and Proper Use of Insulin and Prothrombin Tests, and Speech without Larynx.

The scientific exhibits will be new and worthy of real study and carefully selected technical exhibits will prove helpful and time-saving.

Physicians who have attended previous Clinical Conferences know their value and will plan to attend in 1951. This Annual Conference should be a must on every physician's calendar as it has earned the reputation of being one of the outstanding medical conferences in the country.

## A DERMATOLOGIST REPLIES

To the Editor:

In your editorial "Dermatology Today and Tomorrow" which appeared in The Illinois Medical Journal October 1950, you pointed out some shortcomings that might be remedied in the field of dermatology. These shortcomings have been remedied due to the rapid advances in this field. It is not true as you state in the editorial that dermatologists "confine their consultation to examining the skin and writing a prescription for a stimulating or soothing ointment". That may have been true in 1900, but is no longer true in 1950 when a dermatologist has at his command and uses daily physical modalities which were unknown some fifty years

ago, eg, x-ray, radium, ultraviolet light, carbon dioxide snow, cautery, etc. (*X-ray and Radium in the Treatment of the Diseases of Skin* by Mac Kee and Cipollaro, this is the Bible used by both dermatologists and radiologists. The authors are both dermatologists).

Allergy of the skin as is well known has been brought to the attention of the medical profession as a whole by a dermatologist—namely Marion Sulzberger. Dermatologists were the first to show the psychosomatic relationship of hives, neurodermatitis and a host of other dermatoses. Injections of antibiotics, vaccines and various chemicals have been used in the treatment of various skin diseases for many years and were first introduced by dermatologists for the treatment of skin diseases. The exanthameta were first described by dermatologists, and there is a book that I might bring to your attention *Skin Manifestation of Internal Disorders* written by a dermatologist. For the past several years and at the present time dermatologists have been doing intensive research on lupus erythematouses, dermatomyositis, sarcoidosis and psoriasis. If these facts had been known, I am sure that the editorial that appeared in your journal would have been more understanding and comprehensive.

Very truly yours,
J. M. Greenhouse, M. D.
East St. Louis, Ill .

## MORE ON MULTIPHASIC SCREENING

October 6, 1950

Harold M. Camp, M.D., Editor
Illinois Medical Journal
Monmouth, Illinois
Dear Dr. Camp:

In regard to the editorial "Multiphasic Screening" published in the Illinois Medical Journal. Vol. 98, No. 3, I would like to discuss certain of the statements made by the editor. The 1949 American Medical Association stated, "PUBLIC HEALTH IS THE ART AND SCIENCE OF MAINTAINING, PROTECTING AND IMPROVING THE HEALTH OF THE PEOPLE THROUGH ORGANIZED COMMUNITY EFFORTS. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of diseases, with persons requiring hospitalization to protect the community and with the medically indigent." This would seem to indicate that the health departments could properly be interested in the multiphasic screening program.

The aim of this type of procedure is to discover illness in persons presumably well and have them placed under medical supervision. I think you will admit that the "physician who is in practice and in daily contact with the sick" will not ordinarily be examining these presumably healthy people. The Richmond, Virginia plan has worked out with the local medical society and all reports were sent to the private physicians of the persons examined.

As an ex-chairman of the Section on Preventive Medicine and Public Health, I would recommend that the State Medical Society with the aid of the State Department of Public Health, set up a policy on these programs which would enable us as health officers to establish these programs in our areas when desired and which would protect the interests of the family physicians of the persons screened.

Sincerely yours,
John B. Hall, M.D., M.P.H.
Director, Cook County
Department of Public Health

(Editor's Note) We have no objection to multiphasic screening as a diagnostic procedure and stated so in the editorial. We object to the argument that it is being advocated as a means for the control of chronic disease. In addition, we believe that the practicing physician has the equipment and the ability to do these tests. Furthermore, they should take the lead in this matter or become co-participants with the health department performing these procedures. Organized medicine remembers what happened when the public health department began to do serological tests in order to wipe out venereal disease. We should have some assurance that multiphasic screening will not be followed also by the treatment of the abnormalities which are uncovered.

# ORIGINAL ARTICLES



# Bursitis

**Theodore T. Stone, Ph.D., M.D., F.A.C.P.**

**Chicago**

Bursitis, a not too rare clinical entity is herewith being reported because it has not been readily diagnosed and because it does not appear in any of the new or old neurological text books (except in one). The author believes that this syndrome should be included in all the text books in neurology either in a special chapter on muscles, nerves and painful lesions or to be discussed in the differential diagnoses in the above mentioned chapters. It is hoped that the reporting of nineteen cases will stimulate the practitioners in the early appreciation and recognition of such an entity and, therefore, diagnose and treat these patients earlier than before. It will be seen later that in thirteen cases the diagnosis was not made until eight to twenty-three months had passed from the onset of the bursitis. This delay in recognition of the entity caused unnecessary suffering and extra expenditures of money. In the one neurological text book[1] the author stated that this condition is; readily distinguished by the local tenderness of the deltoid and acromial bursae and supra spinatous tendon; there is limitation of the arm movement due to the pain associated with the bursitis; there is no muscle weakness; Roentgen Ray examination of the involved region will show an area of calcification or a shadow of calcification. In some instances (very early) such calcific areas are not visualized. Rose and Carless[2] say that bursae are normally present in twenty-eight regions of the body. They further stated that in many parts of the body exposed to pressure the bursae make an all out attempt to diminish friction and permit a gliding movement. Where in regions exceptional pressure is brought to bear on some prominent structures adventitious bursae are formed and consist of a bibrous wall lined by a serous membrane con-

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(1). Alpers, Bernard J. Clinical Neurology. Second Ed. Page 156. F. A. Davis Co. 1949.

(2). Manual of Surgery. Rose & Carless. Pages 427-428. Published 1917 in London by Bailliere, Tindall & Cox.

taining a small quantity of serum. Examples of such bursae are (1) porters, who have pressure exerted over the vertebral prominens — this is also known as "hummy"; (2) fish carriers have bursae under the center of the scalp and; (3) there are some bursae over bony prominences arising from malformation or displacement, that is, over cuboid bone in talipes-equinovarus; (4) house maids' knee due to effusion in the pre-patellar bursa.

There are several types of bursitis according to Rose and Carless. These are: (1) acute simple bursitis occurring in gouty and rheumatic individuals. Moderate injuries to these bursae will produce at first a bursitis and later there results a ring or area of calcification; (2) acute suppurative bursitis caused by infections from within or without; (3) chronic bursitis with or without effusion is a rather common form. All of our nineteen cases are from this type. One is where a cavity or bursa is found to be distended with serum. The other is of long standing and occurs more often than any others. Here the bursal wall is usually reticulated and dense and has adhesions, papilliform processes and fibrous cords; (4) chronic fibroid bursitis; (5) chronic tuberculous bursitis; (6) syphilitic bursitis; (7) gouty bursitis. The following areas have special bursae: (1) pre-patellar bursa (housemaids' knee); (2) bursae in popliteal space; (3) bursae beneath the insertion of the semitendinosus and gracilis; (4) bursa beneath tendo Achilles; (5) bursa beneath psoas tendon; (6) gluteal bursa; (7) bursa over the olecranon; (8) bursa over tuber ischii; (9) subdeltoid and acromial bursa.

*REPORT OF CASES.* The nineteen cases were seen by the author and were not classified until then. There were eleven females and eight males. The average age in the females was fifty-four years and in the males, fifty-six years. All of the cases were unilateral, fourteen on the right side and five on the left. The subdeltoid bursa was involved in sixteen instances and the acromial bursa in three. The duration of symptoms before a proper diagnosis was made was as follows:

| | | | | | |
|---|---|---|---|---|---|
| 1 | was diagnosed | 2 months after onset | 2 | " | " |
| 3 | were " | 4 " " " | 13 | " | " " |
| 2 | " " | 5 " " " | 15 | " | " " |
| 4 | " " | 8 " " " | 17 | " | " " |
| | | | 23 | " | " " |

The x-ray findings were positive in 16 cases and were negative in 3 cases. The positive Roentgen findings in 16 cases showed an irregular ring or area of calcification in either the subdeltoid or acromial bursae. Two of these positive cases were found to have a shadow of calcific substance in the above areas. Three cases showed negative Roentgen findings. This clinical study revealed the following symptoms and signs: (1) Severe pain was present in all cases over the deltoid or acromial bursae. (2) Fifteen cases showed marked local tenderness in the involved regions. (3) The deep reflexes and sensation in the involved extremity were normal in all cases. (4) Limitation of motion in the individual involved arms was found in 14 cases. These patients said that the pain was responsible for this difficulty. (5) There was no muscle weakness in any of the 19 cases. (6) Positive Roentgen signs were found in 16 cases. (7) Only 10 patients showed the bursal wall to be reticulated, dense and made up of fibrous cords. (8) There was a history of gout in only one case and a history of chronic rheumatism in another. The past history was of no significance in the other 17 patients.

There are three methods of therapy of bursitis. They are: (1) x-ray irradiation of the calcified ring or shadow; (2) surgical removal; (3) injection of a local anesthetic (3 to 5 c.c.) into the calcified ring or shadow. This is best done under fluoroscopy. All of our 19 cases received 4 or 5 x-ray irradiations in a period of 2 to 3 weeks. All have made a complete and permanent recovery. After each x-ray treatment there was an exacerbation of severe additional pain in the involved areas. Two weeks after the last x-ray exposure the pain vanished and has not returned to date.

*SUMMARY.* Nineteen cases of chronic subdeltoid and acromial bursitis are herewith reported. All of them are of the chronic type. Sixteen showed positive evidence of calcific deposits or shadows in the involved bursae either in the right and left upper extremities. All of them made an excellent and permanent recovery with four or five x-ray irradiations. In three cases showing no positive x-ray findings a diagnosis

of bursitis was made because of the severe pain over the subdeltoid and acromial bursal regions. X-ray irradiations produced a cure in these three cases. These nineteen cases having severe pain in either the arms or shoulders makes it necessary, in the opinion of the author, to consider it in the differential diagnoses of various syndromes in the shoulder and arm. It also should be considered in the differential diagnosis of cervical rib, affection of the scalene anticus muscle, various and sundry joint problems such as arthritis, fractures, dislocations and neoplasms.

30 No. Michigan Avenue

# Trends in Tuberculosis Work

**Otto L. Bettag, M.D.**
Tuberculosis Control Officer, City of Chicago, and
Medical Director, Municipal Tuberculosis Sanitarium.
and
**Meyer R. Lichtenstein, M.D.**
Chief, Medical Service, Municipal Tuberculosis Sanitarium, Chicago.

This paper is intended as a brief resume of the advances being made in tuberculosis work at the present time. The attack on diseases of the chest is progressing rapidly in several different directions. This brief outline is primarily for those who are not familiar with this branch of medical work.

*Case Finding.*—Case finding methods are being extended and improved. Mass x-ray surveys are being used on an ever increasing scale. The photofluorograms are of great value not only to detect tuberculosis but also to detect cardiac disease and carcinoma of the lungs. In the search for tuberculosis, the finding of earlier cases by the mass x-ray survey brings about a much higher percentage of rapid arrest of the disease. It also prevents the dissemination of the disease among a greater number of contacts.

Mass surveys, wherever done in this country, almost uniformly discover that about 0.1 per cent of those x-rayed have active pulmonary tuberculosis. These are commonly asymptomatic persons, often engaged in their usual occupations. The death rate from tuberculosis increases with age in males, and therefore surveys of elderly men are of exceptional value. Many of these individuals masquerade as cases of chronic bronchitis and spread tuberculosis among their contacts.

Besides tuberculosis, the mass survey has been found of exceptional value in uncovering cardiovascular disease and tumors of the chest contents. The possibility of finding carcinomas of the lung while still amenable to cure by pneumonectomy is of tremendous importance.

The routine hospital admission chest x-ray is an important method of survey. If each hospital took a routine chest film on the admission of every patient, there is little doubt that a great many cases of tuberculosis would be uncovered. At present it is commonplace for a patient with pulmonary tuberculosis to enter a hospital and receive treatment for various conditions and be discharged without a diagnosis of his pulmonary lesion. Everyone who is familiar with tuberculosis realizes that active cases with positive sputum are frequently asymptomatic and that it is often impossible to discover such cases by physical examination alone. The chest film is a necessary part of diagnosis in many cases. Every patient who enters a hospital is entitled to a complete diagnosis and a chest film is necessary for this purpose. Hos-

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pitals are being urged to put this into effect but thus far only a small percentage is doing so. Every physician should urge his hospital to institute this advance in the diagnostic management of patients.

No physician is doing his duty in tuberculosis case-finding unless he routinely obtains chest films of all diabetics and all pregnant patients. These two groups require constant observation.

*Diagnostic Consideration.*—The diagnostic use of tuberculin is becoming ever more important because of the increasing number of negative reactors among the general population.[1] Any patient who does not react to an adequately done tuberculin test almost certainly does not have tuberculosis. An adequately done test requires the use of two strengths of tuberculin by intra-cutaneous injection. This should be done preferably with tuberculin P.P.D. (purified protein derivative), first strength and second strength. O.T. (old tuberculin), in equivalent strengths, is now being furnished gratis by the Illinois Department of Public Health.* Their material can be kept at room temperature for many months without deterioration, because of a special diluent. Physicians would do well to keep tuberculin records on all their patients.

Increasing knowledge of chest diseases requires a warning as to the limitations of the diagnostic x-ray film. Final diagnosis should not be made upon the x-ray appearance of the lesion alone. Many other diseases may simulate the appearance of tuberculosis on the x-ray film. It is absolutely necessary to use all the diagnostic means at our disposal in verifying the exact diagnosis in every case. No patient has a thorough workup for tuberculosis unless the following has been done: history (including industrial history), complete physical examination, chest x-rays, Mantoux tests and sputum examinations. Sputum cultures, gastric wash cultures and guinea pig inoculation may also be necessary. Bronchoscopy, bronchograms and other special tests may be needed.

Among the new laboratory methods which appear promising is the slide culture technic. At present, culture of sputum or gastric washings for tubercle bacilli requires a wait of three to eight weeks. With the slide culture method, which is now in its experimental stages, this wait may be cut to six days or less. If and when this method becomes usable on a large scale, it will be of great aid in the rapid diagnosis of patients with pulmonary tuberculosis.

*Therapeutic Considerations.*—Dihydrostreptomycin has practically replaced streptomycin because of its lower toxicity. It can by no means be considered curative in pulmonary lesions but is very valuable as an aid in the management of many patients. It is particularly helpful in those patients with complications such as tuberculous laryngitis[2], enteritis[3], endobronchitis, draining sinuses and fistulas[4]. In miliary tuberculosis and tuberculous meningitis, its use may be life saving, although the percentage of ultimate cure is not large.

Recently para-amino salicylic acid has been added to our armamentarium.[5] This simple drug is a bacteriostatic agent against the tubercle bacillus. It is particularly useful because it can be given orally and has very little toxicity. Furthermore, resistance to the drug rarely occurs and it may be given over a period of many months or possibly years. It has recently been found that the combination of dihydrostreptomycin and PAS has great advantages. At the Municipal Tuberculosis Sanitarium of Chicago we routinely give one gram of dihydrostreptomycin twice weekly and three grams of PAS four times daily for periods of sixty to ninety days. Such combination therapy has been found to be very effective. It has the additional advantage that resistance to streptomycin is considerably delayed. It thus becomes possible to use streptomycin repeatedly or over longer periods of time.

TB-1 (thiosemicarbasone) is a new drug, still in the experimental stage of development. Toxic reactions are quite marked in its use. Its effectiveness has not yet been determined but opinion in this country appears to indicate that it is not as effective as PAS or streptomycin. It may possibly have some use in the treatment of complications in patients who are resistant to other drugs.

*Collapse Therapy.*—During the past few years there has been a marked tendency toward increasing the use of pneumoperitoneum and a corresponding decrease in the use of pneumothorax. The main reason for this trend is the attempt to avoid the complications of pneumo-

*Personal communication. Clifton Hall, M.D., Bureau of Tuberculosis, Illinois Department of Public Health.

thorax. Empyema and air embolism constitute extremely serious complications. Inadequate collapse of cavities because of extensive adhesions frequently renders pneumothorax ineffective. Pneumoperitoneum, on the other hand, has very few complications and is therefore a relatively safer procedure. It is of value in bilateral pulmonary disease and may be useful after pneumothorax has failed. Because of these facts, pneumoperitoneum is now being used about four times as often as pneufothorax. In spite of this, however, pneumothorax is still the procedure of choice where an effective collapse can be obtained for unilateral disease with suitable indications.

*Surgery.*—Thoracoplasty is being resorted to earlier than before. In patients with unilateral apical cavities not amenable to other forms of treatment, it is best to do the surgery early. Prolonged waiting may result in disease of the opposite lung. Excellent results are being attained with thoracoplastics on increasing numbers of patients. Quick conversion to negative sputum and return to useful occupation are achieved in about seventy-five per cent of patients suitable for this operation.

Extrapleural pneumothorax is a useful procedure for a small percentage of patients having the proper indications. Paraffin packs and plastic substances are useful in a limited number of patients.

Pneumonectomy, lobectomy and segmental resections are being used on an increasing scale, both in tuberculous and non-tuberculous diseases of the lungs. Cavities of the lower lobes, which are frequently difficult to collapse adequately, can often be dealt with effectively by lobectomy. The so-called "destroyed lung" with extensive necrosis can be removed in toto by pneumonectomy. These procedures have become much more feasible since the availability of chemotherapeutic agents. It appears probable that the indications for resection of the lung for tuberculosis will be clarified and defined more accurately in the near future.

Exploratory surgery of the chest is mandatory in the presence of a pulmonary nodule which cannot be explained after the usual workup. If bronchoscopy and Papanicolaou stain are negative, exploration should be done at once, so that carcinoma may be dealt with before metastases occur. To wait and observe such cases over a period of time may result in avoidable mortality. Early pneumonectomy is the only measure which can give complete cure of bronchiogenic carcinomas.

*Prophylaxis.*—Isolation of the positive sputum patients with tuberculosis in sanatoria remains the most important method of prophylaxis available. It has been the main factor in the tremendous reduction of mortality from tuberculosis. Early discovery and immediate isolation of patients are the most effective means at our disposal in cutting down the incidence of this disease. The prevention of infection in the Middle West has reduced the percentage of tuberculin reactors to a low level.

The use of BCG vaccine (Bacillus Calmette-



**Mt. Vernon State Tuberculosis Hospital for occupancy during 1951.**



**Chicago State Tuberculosis Hospital to be completed during 1951.**

Guerin) in the prophylaxis of tuberculosis is a controversial issue at the present time. Those who favor its widespread use point to its apparent effectiveness in reducing the mortality in some of the Scandinavian Countries; others point out that the mortality rate has dropped as much in Iceland, where BCG was not used. Many important questions regarding the effectiveness and duration of resistance from BCG are as yet unanswered. Whether BCG is used or not, however, it should be remembered that isolation is still the most effective means at our command.

*Increasing Facilities.*—The shortage of hospital beds for tuberculosis patients will soon be improved by the new State Tuberculosis Hospital built at Mt. Vernon, Illinois, (100 beds), and the one under construction in Chicago (500 beds). In Chicago alone there are approximately one thousand five hundred known cases of tuberculosis which are not in hospitals.

Tuberculosis patients in Cook County but not residents of Chicago are being "farmed out" to nearby sanatoria until the Suburban Cook County Sanitarium District Board can build their own facilities of approximately 300 beds. Additions have recently been made to the Peoria and Rockford Municipal Tuberculosis Sanitaria.

## CONCLUSIONS

Tuberculosis work is becoming much more complex but has been much more effective within the past few years. The use of chemotherapy, collapse therapy or surgery, separately or in combination, is rendering the prognosis much better. Tuberculosis is still a large scale problem, however, and a great deal of active work, over a long continued period, will be necessary to reduce its incidence to a minimum.

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# The Rehabilitation of the Stutterer

**Wendell Johnson, Ph.D.**

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*I. Description Of The Disability As It Is Manifested In Children And Adults.*—Stuttering (sometimes called stammering) is a form of anxiety-tension, manifested as a disturbance in the fluency of speech. Blocks may be seen as delay in initiating speech, tense pauses, repetitions or prolongations of sounds, or interjection of sounds, frequently accompanied by grimaces, bodily movements, holding of breath, etc. In the average adult stutterer, roughly 8 to 10 per cent of the words are affected. There is marked variation in the stutterer's performance, ranging from practically no stuttering in singing, rhythmic speech, chorus speaking, speaking when alone, etc. to relatively most severe difficulty as a rule in situations involving unusual demands for clear and effective communication to important or overly critical listeners.

In very young children the disturbance, if it can be so-called, is scarcely distinguishable from normal speech, involving chiefly or solely easy, simple repetitions of syllables, words, or phrases to a degree usually within the normal range for early childhood speech. With increasing self-consciousness and anxiety, traceable generally to inept handling by parents or teachers, tension appears, the easy repetitions give way to blocking in its more aggravated forms, and the effects of the resulting social handicap and frustration become increasingly apparent and significant.

The average age of onset is about three years; in few cases does the difficulty begin after the age of six years. The ratio of male to female stutterers varies with age level and certain family and environmental conditions, ranging from 1 to 1 to 10 to 1. From 6 to 10 out of every 1000 persons are stutterers. They comprise one of our comparatively large handicapped groups.

*II. The General Effect Of The Disability On The Person's Social, Educational, And Vocational Adjustment.*—Although equal in mental ability to non-stutterers, stutterers are retarded in school, at the eighth grade level, up to one year on the average. College stutterers average about 10 I.Q. points above the average student, indicating that only the brighter stutterers tend to undertake higher education. No adequate estimates of vocational disadvantage have been made, but general knowledge indicates that the handicap probably amounts to an average of roughly 25 per cent at least in earning power. During World War II about half of the stutterers who were examined at induction stations were accepted, and there seems to be no clear basis for differentiating them from those who were rejected; evidently as a group they made a commendable showing in the armed forces, many achieving officer rank. Clinical and test studies of personality have shown that as a group stutterers do not satisfy significantly the criteria of the psychoneuroses. They come close to approximating general population norms. Their special areas of maladjusment center around the anxiety reactions they tend to make to the embarrassing and handicapping frustrations arising out of their stuttering. Personal and social maladjustments, due to this or other factors, tend, when present, to aggravate the speech difficulty.

*III. Present Knowledge Regarding Etiology.*—Theories of causation range from those featuring heredity, constitutional predisposition, or neurophysiological instability (e.g., "cerebral dominance" and "biochemical inbalance" hypotheses) to those emphasizing psychological factors (e.g., the psychoanalytic, conditioned response, and semantogenic theories). Most of the scientific studies of stuttering have been made since 1925, and as research methods have become increasingly refined and dependable, less and less support has been forthcoming for any organic or physical theory of stuttering, and more and more support for psychological hypotheses has been accumulated. Currently, the theory

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that stuttering is a *learned* form of hypertonic avoidant behavior, motivated by anxiety concerning the anticipated occurrence of non-fluency and its social consequences, appears to be receiving particularly serious consideration by the majority of speech pathologists most closely concerned with laboratory and clinical studies of the problem. The issue is not closed, however, and much research remains to be done.

IV. *Present Methods In Examination And Diagnosis.*—Distinctions must be made between stuttering and certain other stutter-like disturbances, such as those seen in certain cases of brain damage, certain clearly psychoneurotic mechanisms, and the excessive nonfluency or cluttered speech of some normal speakers. The distinctive feaures of stuttering are: (a) rather well defined and consistent patterns of tension; (b) characteristic affective reactions, particularly a clearly focused anxiety regarding anticipated non-fluency; (c) predictable variations and consistencies in stuttering with specified changes in conditions (marked reduction in frequency of stuttering with repeated reading of a passage, elimination of stuttering during chorus reading, practical elimination of stuttering under conditions of a masking noise which prevents the stutterer from hearing his own voice, etc.).

The case history should stress particularly the conditions surrounding the onset; parental policies and parent-child relationships; social experiences crucial in the development of the problem; conditions under which severity is increased or decreased; and the imporant details of the presenting problem viewed comprehensively. Due attention is to be given also to the general developmental, medical, school, social and family history.

In the majority of cases stuttering appears to develop *after diagnosis.* It is practically always first diagnosed by laymen, usually the parents, rather than experts, and what these laymen diagnose as stuttering is, as a rule, merely the repetitions and hesitations characteristic of *normal* childhood speech. Studies made in Iowa Child Welfare Research Station and the University of Iowa Speech Clinic have established the fact that all children between the ages of 2 and 6 years repeat sounds, words and phrases, the average child showing 45 such repetitions per 1000 words. The resulting parental concern, and admonitions to the child to go slow, take his time, start over, stop and think, take a breath, etc., tend to bring about the tensions, anxiety and blocking symptomatic of stuttering. Other possible patterns of onset conditions are also to be checked. The details of the stuttering behavior, as observed, are to be recorded. Psychological tests and physical examination procedures are to be employed as indicated.

*V. Present Methods of Treatment.*—Very young stutterers are nearly always best treated indirectly by means of properly detailed counseling of the parents. In some cases techniques such as play therapy may be indicated. Modifications of aggravating parental attitudes and policies and details of home management are almost always advisable. The majority of very young stutterers respond well and fairly rapidly to such relief of environmental pressures, provided they have not yet developed well established anxiety-tension response patterns.

Stutterers who have developed marked anxiety-tensions respond less well to treatment, but worthwhile relief can be achieved in most cases and complete or nearly complete recovery is not extremely rare. Chronic stutterers almost always require therapy, together with such environmental modifications as can be managed. Direct treatment divides generally into (a) psychological counseling and (b) directed changes in habitual speech performance. Properly instructed, most stutterers can learn to do their stuttering more simply, with decreased tension, and less emotional disturbance. In many modern clinics voluntary or purposeful stuttering is advocated accordingly—and also as a direct means of reducing anxiety, in accordance with the old rule of combating a fear by doing the thing one is afraid to do. Detailed procedures are to be found in Chapters 2 and 5 and the appendix of the book, *Speech Handicapped School Children,* and in other references listed at the end of this article.

Some therapists favor slow or rhythmical speech patterns, "chewing" speech, and other techniques which are designed to insure relatively immediate and complete fluency. Other therapists look with disfavor on such practices, contending that they ignore fundamental motivation underlying the stuttering, and are essentially anxiety-producing. In general, the present-day stuttering specialists employ a comprehensive approach, striving in individual cases for a proper balance of psychological counseling, en-

vironmental modification, alteration of the stuttering pattern, and speech practice. It appears to be particularly important to bring about a marked increase in the amount of talking and social participation by the stutterer.

VI. *General Criteria Of Successful Clinical Results And Outcomes Of Treatment.* Improvement is to be gauged in many ways, such as: (a) decreased frequency of stuttering in specified situations; (b) decreased tension and complexity in the stuttering pattern; (c) a more frank and unemotional attitude toward the difficulty; (d) an increase in amount of talking done and in the variety of situations in which it is done; (e) improved feeling tone and more positive self-evaluations; (f) improved social relationships, etc.

VII. *Agencies And Resources That Must Be Enlisted In The Management Of These Disorders.*—Professional qualifications essential for clinical work with stutterers are defined by the American Speech and Hearing Association, the professional organization in this field. Highly qualified speech pathologists characteristically hold the Ph. D. degree in speech pathology, which today is obtainable in several American universities. In treating stuttering, the speech pathologist properly works in cooperation not only with the physician, psychologist and sometimes the psychiatrist, but also with the stutterer's teachers, employers, club leaders, associates and family. In modern clinics and in public school programs group therapy is customarily combined with individual instruction and counseling, and proper attention is given to the stutterer's activities outside the clinical periods. It is a program requiring teamwork among all those who influence the stutterer's speech adjustments.

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## THE PHILOSOPHY OF HEADACHE

Much has appeared in recent literature on the subject of the symptom, headache. Patients and profession alike seek a certain cure, preferably simple to prescribe, easy to use, universal in applicability, and as dependable as a guillotine in relief of head pain. Actually, the cause and the cure of intrinsic headaches lie within the individual; the cause and the cure of secondary headaches depend upon the pathogenesis and the treatment of the primary disease. There is no royal road to either cure, for patient or for physician. He who would cure headache, his own or someone's else, must be infinitely patient, anatomically, physiologically, and psychiatrically curious, and able to face failure with resource.

By intrinsic headaches are meant those headaches not secondary to a known disease process, i.e., migraine, histaminic cephalgia, tension headache and muscle tension headache. These, and the secondary headaches which may occur in hypertension, myofibrositis, arterio-sclerosis, allergy, and psychoneurosis make up the bulk of chronic headaches seen in daily practice and demanding medical intervention. *Excerpt: Office Management of Some Common Types of Headaches, Dorothy Macy, Jr., M.D., M.S. (Med.), associate in medicine, Woman's Medical College of Pennsylvania, J.A.M.W.A., Sept.,* 1950.

# Medical Treatment of Epilepsy Today

**John S. Garvin, M.D.**
**Chicago**

This survey has been prompted by a desire to evaluate and present the current medical treatment of epilepsy. Five hundred patients from the Neurological and Epilepsy Clinics of the Illinois Neuropsychiatric Institute were included in this series. All have had electroencephalographic studies and have been followed for at least four months while on their most recent type of medication. Most of these patients have been referred to the Clinics because of difficulty in controlling seizures and hence represent a selected group. Particular attention has been paid in this survey to the clinical type of seizure, the electroencephalographic findings, response to treatment, and certain aspects of prognosis.

The patients have been divided into groups on a clinical basis, using diagnoses of grand mal, petit mal, psychomotor, or Jacksonian seizures (or a combination of these). Those patients with an aura, loss of consciousness, generalized tonic-clonic convulsion, tongue-biting, and incontinence have been placed in the grand mal category. The petit mal type consists of momentary black-outs accompanied at times with vasomotor disturbances, blinking of the eyelids, without aura, and occurring most frequently in childhood. The psychomotor type includes psychic auras, impairment of consciousness, confusion, dream-like trances, and automatisms such as plucking movements of the hands, swallowing, or chewing movements. The patients may carry out complicated coordinated activity for which they are amnesic. The term Jacksonian epilepsy has been used for cases of focal seizures (whether or not they consist of a progressive march).

Seventy-six per cent of the cases were of the grand mal type either alone or in combination with petit mal or psychomotor seizures (Table 1). Thirty-eight per cent of the patients had psychomotor or psychomotor and grand mal seizures, a figure which is comparable with that of 40% found by Roseman[1]. The number of pure petit mal cases in our series is small because the majority of these patients are children and are treated routinely in the Pediatric Clinic. In general, it is those children with a combination of seizures or those who do not respond to medication who have been referred to the Neurological or Epilepsy Clinic. Forty-two per cent of the patients had more than one clinical type of seizure.

TABLE 1

CLINICAL CLASSIFICATION

| CLINICAL DIAGNOSIS: | # CASES | % |
|---|---|---|
| Grand Mal | 169 | 33.8 |
| Psychomotor | 57 | 11.4 |
| Petit Mal | 12 | 2.4 |
| Jacksonian | 39 | 7.8 |
| Grand Mal and Psychomotor | 135 | 27.0 |
| Grand Mal and Petit Mal | 76 | 15.2 |
| Grand Mal, Psychomotor, and Petit Mal | 2 | 0.4 |
| Atypical | 10 | 2.0 |
| TOTAL | 500 | 100.0 |

## ELECTROENCEPHALOGRAPHIC FINDINGS

The percentage of normal electroencephalograms differs markedly for each type of epilepsy (Table 2). In those patients who clinically had only grand mal seizures approximately 20% had normal electroencephalograms and only 49% had seizure discharges. Eighty-seven per cent of the patients with clincal psychomotor attacks showed seizure discharges in their electroencephalograms. Not one of the patients with a combination of grand mal and petit mal attacks had a normal electroencephalogram, and 95% had seizure discharges. Interestingly enough, only 64% of the patients with Jacksonian epilepsy had focal abnormalities in their electroencephalogram even if amplitude asymmetry is included as an abnormality.

The high percentage of abnormal electroencephalograms may be accredited to the fact that most of these patients had sleep studies, especially those who showed no abnormality during

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TABLE 2

RESULTS OF ELECTROENCEPHALOGRAPHIC STUDIES

| Clinical Diagnosis | Normal E.E.G. | | Abnormal E.E.G. | | | | | | | | Total Cases |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Abnormal Frequency | | Seizure* Discharge | | Slow-Wave Focus | | Amplitude Asymmetry | | |
| | # | % | # | % | # | % | # | % | # | % | # |
| Grand Mal | 33 | 19.5 | 46 | 27.2 | 83 | 49.0 | 7 | 4.1 | — | — | 169 |
| Psychomotor | 5 | 8.7 | 2 | 3.5 | 50 | 87.7 | — | — | — | — | 57 |
| Petit Mal | — | — | — | — | 12 | 100.0 | — | — | — | — | 12 |
| Jacksonian | 1 | 4.4 | 13 | 10.2 | 28 | 71.8 | 2 | 5.1 | 4 | 10.2 | 39 |
| Grand Mal and Psychomotor | 6 | 4.4 | 13 | 9.6 | 114 | 85.1 | 2 | 1.4 | — | — | 135 |
| Grand Mal and Petit Mal | — | — | 3 | 3.9 | 72 | 94.7 | 1 | 1.3 | — | — | 76 |
| Grand Mal, Petit Mal, Psychomotor | — | — | 2 | 100.0 | — | — | — | — | — | — | 2 |
| Atypical | 2 | 20.0 | 1 | 10.0 | 6 | 60.0 | 1 | 10.0 | — | — | 10 |
| TOTAL | 47 | 9.4 | 71 | 14.2 | 365 | 73.0 | 13 | 2.6 | 4 | 0.8 | 500 |

*The type of electroencephalographic seizure discharge has not been specified. In some cases, the type of seizure discharge does not correspond with that of the seizures observed clinically. When both abnormal frequencies and seizure discharges were seen, the record was classified only under the category of seizure discharges.

the waking record. One can see (Table 2) that the per cent of epileptics with normal electroencephalograms may vary from 0 to 20% depending upon the type of clinical seizure. This wide variation may explain the differences obtained by other workers such as Abbott and Schwab[2], Jasper[3], and Finley[4], whose series have not been so subdivided.

## RESULTS OF TREATMENT AND PROGNOSIS

The response of patients to medication was divided into four groups: (1) seizure-free, (2) greatly improved (75-100% reduction of attacks), (3) moderately improved (25-75% reduction of attacks), and (4) no effect (less than 25% reduction of attacks). The results of treatment vary with the type of seizures (Table 3). The prognosis is dependent upon the type of seizure, the frequency of clinical attacks, and the electroencephalographic findings.

Forty-seven per cent of the patients with grand mal seizures were seizure-free while only 15% were unimproved. Many of these patients have been seizure-free for two or three years and some for as long as ten years. Of the 80 seizure-free patients, 27% had normal electroencephalograms while another 31% had only an abnormal frequency with no seizure discharges. An excellent prognosis for complete control of attacks may be given when the clinical attacks are relatively infrequent and there is a normal electroencephalogram. The patients with the poorest prognosis are those with fairly frequent attacks and electroencephalographic abnormalities of a

TABLE 3

RESULTS OF THERAPY

| Clinical Diagnosis | Seizure Free | | Greatly Improved | | Moderately Improved | | No Effect | | Total Cases |
|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # |
| Grand Mal | 80 | 47.3 | 40 | 23.6 | 24 | 14.1 | 25 | 15.0 | 169 |
| Psychomotor | 6 | 10.5 | 26 | 45.6 | 10 | 17.5 | 15 | 26.3 | 57 |
| Petit Mal | 4 | 33.3 | 3 | 25.0 | 1 | 8.3 | 4 | 33.3 | 12 |
| Jacksonian | 7 | 17.9 | 16 | 41.0 | 7 | 17.9 | 9 | 23.0 | 39 |
| Grand Mal and Psychomotor | 26 | 19.2 | 65 | 48.1 | 20 | 14.8 | 24 | 17.7 | 135 |
| Grand Mal and Petit Mal | 1 | 50.0 | — | — | — | — | 1 | 50.0 | 2 |
| Grand Mal, Petit Mal, and Psychomotor | 1 | 50.0 | — | — | — | — | 1 | 50.0 | 2 |
| Atypical | 2 | 20.0 | 4 | 40.0 | 1 | 10.0 | 3 | 33.3 | 10 |
| TOTAL | 145 | 29.0 | 180 | 36.0 | 75 | 15.0 | 100 | 20.0 | 500 |

focal character, especially spike and slow-wave formations.

Ten per cent of the patients with psychomotor seizures were seizure-free for periods of six months to two years. Frequently after a long period with no seizures, these patients again begin to have attacks, and when this happens, they appear especially refractory to medication unless used both in large doses and in combination. Although only 10% of the psychomotor patients were seizure-free, 45% were greatly improved, and some of these patients had attacks so negligible that they were able to maintain full employment. Some of these patients in the psychomotor category have marked personality disturbances when their seizures are stopped or greatly reduced in number. Prognosis for complete control of attacks is poor. The best prognosis is for those patients with infrequent attacks and a normal electroencephalogram both awake and asleep. However, patients with infrequent clinical attacks but with many seizure discharges in their electroencephalogram may respond quite well to medication. Patients with psychomotor seizure discharges in their electroencephalogram have only a 25% chance of being controlled. One must not be too discouraged in regard to prognosis, however, until these patients are given a trial of anti-convulsant medication.

The small number of patients with petit mal seizures limits the value of percentage results. From other reports (Lennox[5], Davis and Lennox[6]) the percentage of patients seizure-free and greatly improved is higher than our figures would indicate.

Eighteen per cent of the patients with clinical Jacksonian attacks were seizure-free, and 41% were greatly improved. It is extremely difficult to determine the prognosis for control of the attacks as it depends to a large extent upon the etiology. One must wait until after a trial of medication before giving a definite prognosis.

In patients with both grand mal and psychomotor attacks, 19% were seizure-free, and 48% were greatly improved. Concerning the prognosis one may state that the grand mal attacks may be stopped even though the psychomotor attacks continue. This explains in part the large number of greatly improved patients in this group. If the electroencephalogram shows psychomotor seizure discharges, these patients have only a 50% chance of their seizures being controlled. As in the pure psychomotor group, if, following a long seizure-free period while on medication, an exacerbation associated with abnormal electroencephalographic findings occurs, the prognosis for renewed control is poor. Control of the seizures of these patients and of those with psychomotor attacks alone depends to a certain extent upon supportive psychotherapy and satisfactory environmental conditions. Whether the psychomotor seizure discharges in the electroencephalogram are unilateral or bilateral, there is no apparent difference in response to treatment.

Twenty-five per cent of the patients with grand mal and petit mal seizures were seizure-free and 34% were greatly improved. The prognosis depends on the frequency of attacks and on the electroencephalographic changes. Electroencephalographic findings of petit mal variant seizure activity associated with slowing or other seizure activity; and petit mal seizure activity with multiple spikes associated with pure grand mal seizure activity carry a bad prognosis.

## TYPES OF TREATMENT

Various anti-convulsant medications have been used on these patients, and it has been possible to evaluate the effectiveness for specific types of seizure. Contrary to the report of Price at al[7], we have found glutamic acid to be of little value. Similarly, the ketogenic diet[8] has been of little value in our group of patients. (This may be due to the fact that the patients usually do not follow the diet because it is rather unsavory.) Bromides have been found to be of some value: however, their anti-convulsant action is much less than that of phenobarbital which has the further advantage of few side effects. Combinations of drugs have been found to be of much greater value than any drug alone, and smaller doses of each drug may be given when used in combination. Usually, the anti-convulsant action of one drug enhances that of the other without increasing the side effects. The exceptions appear to be dilantin [9, 10] and mesantoin[11, 12] which have similar toxic manifestations such as ataxia and nystagmus, and mesantoin[13, 14, 15] and tridione[16, 6] which have a common toxic effect of depression of the hematopoietic activity of the bone marrow.

One of the most effective combinations appears to be dilantin and phenobarbital (Table

TABLE 4

RESULTS OF TREATMENT WITH
COMBINATION OF DILANTIN AND PHENOBARBITAL

| Clinical Diagnosis | Seizure Free | | Greatly Improved | | Moderately Improved | | No Effect | | Total Cases |
|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # |
| Grand Mal | 45 | 41.6 | 29 | 26.8 | 14 | 13.0 | 20 | 18.4 | 108 |
| Psychomotor | 4 | 13.3 | 10 | 33.3 | 6 | 20.0 | 10 | 33.3 | 30 |
| Grand Mal and Psychomotor | 16 | 18.1 | 35 | 39.8 | 13 | 14.8 | 24 | 27.2 | 88 |
| Grand Mal and Petit Mal | 6 | 18.7 | 5 | 15.6 | 6 | 18.7 | 15 | 46.8 | 32 |
| TOTALS | 71 | 27.5 | 79 | 30.6 | 39 | 15.0 | 69 | 26.7 | 258 |

4). This combination is most effective in the treatment of grand mal seizures, maintaining 41% of the patients seizure-free. It is least effective in the treatment of patients with grand mal and petit mal and may cause an increase in the petit mal attacks. It is not indicated in patients with pure petit mal seizures. Patients with grand mal seizures not controlled with a combination of dilantin and phenobarbital may be controlled with a combination of dilantin and mesantoin and phenobarbital, or all three drugs together.

The psychomotor type of seizures is extremely resistant to medication, and it has been found that a combination of drugs, frequently three or four, is invariably necessary. A combination of dilantin, mesantoin, and phenobarbital has proved satisfactory in some cases. Phenacetylurea (Phenurone) has been used in this institution for over two years. A preliminary report by Gibbs et al[17] showed it to be quite effective against psychomotor attacks. Since that report, it has been found to be particularly effective in combination with other drugs in the treatment of psychomotor seizures. Tridione has been reported by Davies and Spillane[18] to increase psychomotor attacks. On the whole we agree with this statement; however, tridione in combination with other anti-convulsant medication is occasionally beneficial in psychomotor cases.

Although the number of petit mal patients in this series was small, and their seizures difficult to control, we agree with Lennox[5], Davis and Lennox[6], and Perlstein and Andelman[19] about the value of tridione in the treatment of these patients. We have also obtained encouraging results with paramethadione (Paradione)[6].

Jacksonian attacks are usually of symptomatic etiology and may be amenable to surgical therapy. The possibility of surgical benefit should always be considered first. Those patients who cannot be helped by surgical measures appear to respond best to phenobarbital alone or to a combination of mesantoin and phenobarbital.

In patients with grand mal and psychomotor attacks, a combination of medications similar to those used for psychomotor attacks is necessary.

Patients with grand mal and petit mal attacks in combination are extremely difficult to treat because dilantin (which is effective against grand mal seizures) frequently causes an increase in petit mal attacks, while tridione (which is effective against petit mal) may cause an increase in grand mal seizures. A combination of medicines is essential to control the attacks of these patients, and the drugs must be balanced individually for each patient. A combination of dilantin and phenobarbital is indicated when grand mal seizures are predominant while tridione and phenobarbital are indicated in those patients with predominantly petit mal seizures. A combination of tridione, dilantin, and phenobarbital may be given in resistant cases and the dosage balanced to control the attacks. Since the original report on phenurone[17], it has been used more and more in patients with grand mal and petit mal attacks. We have found it to be highly effective against both types of seizures and in no instance did it appear to cause an increase in one type of seizure.

Although the clinical seizures of patients with petit mal variant seizure activity in their electroencephalogram vary greatly, often we have found a combination of amphetamine sulfate (Benzedrine) and phenobarbital to be effective.

## DOSAGE OF ANTI-CONVULSANTS

The most frequent mistake in treating epileptics is that of using insufficient quantities of the drug employed. The dosage of anti-convulsants

TABLE 5

DOSAGE OF ANTI-CONVULSANTS

| DRUG | MINIMAL DOSE | AVERAGE DOSE | MAXIMAL DOSE |
|---|---|---|---|
| Phenobarbital | 0.1 grams daily | 0.1 grams daily | 0.1 grams 3x daily |
| Dilantin | 0.1 grams b.i.d. | 0.1 grams t.i.d. | 0.1 grams 5x daily |
| Mesantoin | 0.1 grams daily | 0.1 grams q.i.d. | 0.2 grams 6x daily |
| Tridione | 0.3 grams b.i.d. | 0.3 grams q.i.d. | 0.6 grams 6x daily |
| Bromides | 1.0 grams t.i.d. | 1.0 grams t.i.d. | (Blood Bromide (150-300 mgm.%) |
| Phenurone | 0.5 grams b.i.d. | 0.5 grams q.i.d. | 1.0 grams 5x daily |

which is adequate is highly variable and consequently individualized treatment of the epileptic is necessary. The minimal and maximal doses are given in Table 5; however, it must be realized that the maximal dose of any anticonvulsant for a given patient is that dose which controls the convulsions and at the same time does not cause serious side or toxic effects.

## SIDE REACTIONS AND TOXIC EFFECTS

In this series of patients, there was one toxic reaction to phenobarbital consisting of dermatitis. The side effect most frequently observed is hypersomnia, which, however, is only present with large doses.

Out of 300 patients who had been treated with dilantin, 6.6% developed ataxia, nystagmus, and dizziness. Hyperplasia of the gums was present in 4.3% of the cases, while gastric disturbances (nausea, vomiting, gastric pain, or discomfort) were present in 3.6% of the cases. Three and three tenths per cent developed a rash. Some patients had more than one group of the toxic symptoms listed above. No changes in the blood count were observed. One patient ingested 3.0 grams in a suicidal attempt. The effects were those of heavy sedation and confusion with impairment of coordination. One patient who was receiving extremely high doses of dilantin developed ataxia, nystagmus, diplopia, and hyperplasia of the gums. There was impairment of vibratory sensation in the ankles, and a unilateral Babinski response was observed. These signs and symptoms disappeared with withdrawal of the drug.

Mesantoin and tridione have both been reported to cause agranulocytosis and hypoplastic anemia. Other toxic reactions include rash, fever, and cervical lymphadenopathy. These reactions occur in about 8% of patients taking mesantoin. Whenever these symptoms develop, the drug should be discontinued immediately. Overdosage of mesantoin may cause ataxia, diplopia, nystagmus, and hypersomnia. We have not observed hyperplasia of the gums. When patients are taking either mesantoin or tridione, they should have blood counts at intervals not exceeding one month.

The symptoms of bromidism are well-known, and one must be watchful for mental confusion, rash, and cerebellar symptoms in those patients taking bromides.

Phenurone may cause personality disturbances, anorexia, disturbance in sleep, and in one case in this series, leucopenia. Two patients developed toxic hepatitis. There have been no fatalities in our patients treated with this drug.

## SUMMARY

1. Five hundred cases of epilepsy have been reviewed with respect to type of clinical seizure, electroencephalographic findings, and response to anti-convulsant medication.

2. Grand mal attacks were found in 33.8%; psychomotor attacks in 11.4%; Jacksonian seizures in 7.8%; and petit mal attacks in 2.4%. In 42.6% of the series, there was more than one type of seizure (grand mal and psychomotor seizures were most common). Two per cent were atypical.

3. Almost 20% of those with only grand mal seizures had normal electroencephalograms, while none of those with both grand mal and petit mal attacks had normal brain wave patterns.

4. Forty-seven per cent of patients with grand mal seizures were free of attacks with suitable medication, while only 10% of those with psychomotor seizures could be completely freed of attacks.

5. The prognosis as to control of seizures depends on the type and frequency of clinical attacks and the electroencephalographic findings.

6. Combinations of anti-convulsant medications appear to be more effective than any single drug.

7. The various types of anti-convulsant drugs and combinations of drugs are discussed, and their toxic effects noted.

8. A higher per cent of improvement in the control of epileptic seizures may be obtained with individualized dosage and appropriate combinations of anti-convulsant drugs.

The author wishes to express his appreciation to Mrs. Ashton Graham and Miss Betty Vilas for their assistance and to Drs. Sugar, Bailey and Gibbs for their helpful advice.

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## POST GRADUATE UROLOGICAL SEMINAR

The South Central Branch of the American Urological Society holds its Seminar in Dallas at the Adolphus Hotel, January 29th through February 2nd. We would appreciate it if you would print a notice of the coming meeting in your Journal. Thanking you very much for this courtesy,

R. E. Van Duzen, M.D.
Chairman

Trained employees are more valuable to an organization than new employees, and periodic health surveys may prevent many physical disasters and prolong the working life and capacity of faithful workers. Edward I. Salisbury, M.D., F.A.C.S., New York State J. Med., September 15, 1950.

We may yet, through the wonderful persistence of . . . research workers, reach the situation described in Samuel Butler's *Erewhon*, a community in which ill health was regarded as a crime and a man accused of "pulmonary consumption" was convicted and sentenced to imprisonment, at hard labor, for the rest of his miserable existence. Claude M. Fuess, Ph.D., New England J. Med., September 21, 1950.

# The Responsibilities of the Physician — A Problem of Medical Education

## (A Symposium)


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**SEMINAR**
**of the**
**Department of Medicine**
**and**
**Cooperating Departments**
**of**
**The University of Illinois**
**Edited by:**
**Max Samter, M.D.**
**William R. Best, M.D.**

*Dr. Olson*: The distinguished panel which has accepted the invitation of the Department of Medicine to discuss one particular phase of medical education lends weight to the importance of the topic: The Responsibilities of the Physician. I am happy to introduce to you our guests — Dr. Anderson, Dr. Armstrong, Dr. Hoffman, Dr. Manlove, Dean Ryan, and Dean Sheehan. They represent the medical schools of the West Side Medical Center, the Cook County and Presbyterian Hospitals which are an integral part of our teaching schedule, and the Council on Education and Hospitals of the American Medical Association.

I am hopeful that we can reach some definite conclusions in spite of the limited time which is available to us. First, some of my own ideas on the problem which we are about to discuss. It seems to me that the responsibilities of the physician must be divided into (1) his responsibility towards the profession as a whole, and (2) his personal responsibility which extends to the patient as well as to himself and his own conscience.

The professions, as a whole, can set up standards of technical skill as well as standards of conduct. The relative importance of skill vs. conduct varies in the several professions. A clergyman, for instance, has little technical skill but assumes a great deal of personal responsibility, while a civil engineer can work with a great deal of technical skill applied effectively in a detached and impersonal manner. Unlike these extremes, the physician must live up to both. In spite of the recognition of this fact, the emphasis of medical education, at this time, rests on skill and facts, and one wonders often whether we prepare our students adequately for the requirements of their profession. I feel strongly that one cannot divorce scientific accomplishments of medicine from the ethical principles under which they are practiced. In an emergency, for instance, a physician must act rapidly or, as we like to say, "instinctively". Naturally, this "instinct" is a combination of both sound medical training and emotional conditioning — the "responsible physician" must fulfill this dual requirement. I would like to return to the problem of the responsibility of the profession as a whole. Dr. Anderson, how do you feel that the standards set

down by organized medicine the American Medical Association to be specific, might influence the teaching of personal responsibility in our medical schools?

*Dr. Anderson*: The non-scientific responsibilities of the medical profession were well outlined by Roscoe Pound in the New England Journal of Medicine of September 8, 1949.[1] I should like to quote parts of this article directly: "Let me repeat what we mean by the term profession when we speak of the old recognized professions. We mean an organized calling in which men pursue a learned art and are united in the pursuit of it as a public service — as I have said, no less a public service because they make a livelihood thereby. Here, from the professional standpoint there are three essential ideas — organization, learning and a spirit of public service . . . . . .

"The trade association exists for the purposes of the trade as a money-making activity. The medical society exists primarily for the purposes of medicine, not of the doctor of medicine, and for the advancement of the healing art . . . . . What medical associations have done for advancement of medicine I need not recount to you."

I am certain that many of medicine's accomplishments have been possible only because physicians have worked in organized groups. As individuals they would have been unable to advance the art of medicine as effectively and in the public interest. For example, in groups physicians have established acceptable standards for undergraduate medical education. They have improved the intern and resident training and the standards of hospitals. They have stimulated the legislatures to promote health departments, to regulate the traffic in foods and drugs, etc. Much more must be done, it is true. In our educational programs, we should emphasize the responsibility of our students to the society in which they live. Many students are critical of the activities of organized medicine. I suspect much of this distrust arises from lack of proper interest in the activities of medical societies on the part of many teachers.

*Dr. Ryan*: The current attempts to organize a "Student American Medical Association" seems to make possible an important step toward the goal outlined by Dr. Anderson. The students would be represented at the meetings of the American Medical Association — they plan to have a journal of their own, a development which would emphasize to the student that he is already a part of the profession and as such, has an obligation which he must assume. Such groups who have already begun to develop their own school programs would seem to provide an excellent channel through which the student could be indoctrinated in his formative years in the responsibilities, obligations and ethics of the medical profession. Dr. Cole has had much more responsibility than I in the promotion of these efforts locally and I wonder whether he would care to comment on the program.

*Dr. Warren H. Cole, Professor of Surgery*: The student does not get close to the problems of organized medicine until late in his career as a physician. This interest should be stimulated at a younger age — the only way that this can be done is the inclusion of the student in the activities of organized medicine. The "Student American Medical Association" might well be the answer to some of these problems. You must be careful, however, to maintain a balance so that the students' activities are neither too independent nor stifled by too much authority from the parent organization.

*Dean Olson*: The speakers thus far have given us their opinion as to how the professional responsibilities of the medical students can be developed by professional organization. I should like to call on Dr. Armstrong to outline his prescription for the education in personal responsibility of the junior medical student at a time when he first comes in contact with patients.

*Dr. Armstrong*: In a teaching hospital, I feel this can be best done by giving the student the feeling that he is an integral part of the team caring for the patient. This team should consist of attending man, resident, intern, and student, all working towards one common purpose and all sharing some of the responsibility. This is not correlated with the type of bed, private or public, but rather with the type of individual who heads the service. He sets the keynote for the type of cooperation which will be followed through in the management in the teaching hospital. In the old German medical schools there was the Geheimrat type of professor to whom all others on the staff were subordinate and made

[1]New England Journal of Medicine — Sept. 8, 1949, pages 351-357

to feel so. In the German scheme teamwork was virtually unknown. The professor must have the time and willingness to utilize his time in listening to his students and directing their thoughts, both scientifically and ethically. This type of teamwork is desirable, both in teaching and in practice.

*Dr. Sheehan*: I do not want to speak disparagingly of teamwork. However, in recent years the trend has been to emphasize scientific rather than character background in the selection of students. By the time an individual reaches medical school age, his personality is well crystallized. Therefore, one must choose applicants with the type of character thought to be desirable in a physician. This is not easy. In our institution we base this judgment on the testimony of men of discernment who have associated with the candidates. After the students have been admitted to this school, we teach the physician's moral obligation to the patient outright. It depends fundamentally on the individual's philosophy of life. In our thinking this should consist not only of honesty, integrity, and responsibility to society as constituted but should embody a religious responsibility. Intellectual concepts alone are not sufficient motivation. Exposing the student to Christian moral concepts is no problem in our institution. We feel sure that most of our students in their professional lives will be motivated by these principles.

*Dr. Manlove*: At this point I would like to take up Dr. Sheehan's remarks on the proper selection of students. Character can be modified to a certain extent after the individual has been admitted to the medical school. I believe that we underestimate the problems which confront the student who faces the responsibilities of the profession. The Department of Psychiatry perhaps can help somewhat by giving the student insight into the physician-patient relationship, thus helping the doctor to bear the patient's wrath and to eliminate compulsiveness in medicine.

*Dr. Hoffman*: I cannot agree with Dr. Manlove's contention that character can be changed. When I think of the many students, interns, and residents who have passed through our hospital in the former years, I have come to suspect that not much can be done once we get hold of the future physicians. Even at that early station in life a gentleman will behave like a gentleman no matter what situation confronts him, and I suspect strongly that all our efforts will be in vain when we try to make a saint out of the scoundrel. I found that even for the best of us it must make some difference whether we examine the president of the Coca Cola Company or one of the unfortunate victims of circumstances who are brought to a large city hospital. I doubt very much that medical education can accomplish anything in this particlar sphere of personal responsibility. Perhaps there should be a more thorough method of selecting students.

*Dr. Robert W. Keeton, Professor of Medicine*: It seems to me that this discussion of medical education has been slanted toward educating the medical student in honesty, integrity, and courtesy. One must not forget that students arrive at the university after spending fourteen years in school. This includes three or four years in college, in which they have associated with other students in the classroom, on the athletic field, and in social events. By this time they have learned to show respect to their associates and have developed the habits of courtesy. Honesty and integrity are virtues with which the parents and children have been wrestling since birth. At the school age the teachers take up the battle. It would, therefore, be highly unpedagogical to assume that medical students are ignorant in these fields. The problem therefore concerns instruction as to what is honesty and integrity in the field of medicine. It is unthinkable that a student previously known to be dishonest could be converted into an honest gentleman by taking a medical course.

Medical education is a continuing activity. The student begins his instruction in the medical school and continues it after graduation through postgraduate courses, programs of his medical society, and conferences of his hospital staffs. In the medical school his objective is the acquisition of knowledge and after graduation the practice of medicine. In this latter period he is concerned primarily with the application of his knowledge to the relief of suffering and to the provision of a livelihood, and only secondarily to the acquirement of further knowledge.

Medical knowledge consists of (a) factual knowledge, the individual elements of which may be classified as building stones; (b) certain laws

and conventions which can be best described as medical logic. Medical logic consists of the concepts and the partitions into which the facts are fitted together. It is easy to teach facts. But to teach the use of facts requires continuous evaluation on the part of medicine. This is an unending effort not terminated by the end of medical school.

In some people motivation toward the correct solution of medical problems is found in the great satisfaction of solving the problem, in the escape from the proddings of the pathologist's voice in the morgue, and in the reward of grades. The acquirement of medical knowledge teaches honesty in medical matters.

During the period of medical education after graduation, society or other factors may substitute counter motivations which put a stress on honesty. He is not alone in this respect. Every professional man and in fact everybody must select for himself a brand of social behavior. Indeed, the medical man is in a rather favored position. He is a public servant and, as such, subjected to close scrutiny. If he does not apply his factual knowledge to the practice of good medicine, the community soon finds it out and he is branded a poor doctor. When he joins a hospital staff and a medical society he runs into rules to guide his ignorance and curbs to insure that he does not commit a crime in the field of medical reasoning and logic.

*Dr. Hoffman*: In other words, Dr. Keeton, the student must pass the judgment of his teachers. If the members of the staff are idealists and men of high character, the students will naturally emulate them and will thus follow the good life.

*Dr. Olson*: I am impressed by the term "the good life" which Dr. Hoffman has selected. Again and again when a patient is selecting a physician he will ask, "What kind of a doctor is he?" If all physicians were uniformly good this question would not arise. It seems to me we are forced to the conclusion that some physicians must practice in a manner which invites criticism. I can now state my original question in much simpler words. What can we do to educate *good* physicians?

*Dr. George E. Wakerlin, Professor of Physiology*: I believe that there are three areas in which we should encourage education to promote a greater sense of responsibility among medical students. First, the premedical curriculum should include more of the humanities. Second, in medical school a course on the "art of medicine" should be inserted even at the expense of some of the medical sciences. This should include not only ethical concepts but some of the practical business principles for a medical practice. Third, we should teach by precept from the head of the department on down to the intern.

*Dr. Olson*: Dr. Wakerlin has expressed a thought which I believe is of the greatest significance namely that teaching can only be as good as the teachers. We may summarize the discussion by saying that the panel has brought out clearly that the profession organized in effective groups has been able to promote standards for professional responsibility. The continuous effort of the medical schools to graduate students with personal responsibility, on the other hand, depends on the proper selection of students and, if I interpret the consensus of the panel correctly, on teaching by precept. In conclusion we can state with conviction that medical teaching is deficient unless the art of medicine becomes an integral part of the science of medicine.

# Results of Chest X-Ray Screening in Hospitals

**John E. Madden, M.D.**

**Decatur**

By chest screening, for the purposes at hand, we mean the use of photoroentgen technique in some form, the technical factors of which have become more efficient and the necessary procedure has been comparatively simplified. In our city we are using two units; one at Decatur & Macon County Hospital and one at St. Mary's Hospital that are of identical type and a third unit of similar type at the Macon County Tuberculosis Sanatorium. We have not been pioneering, in that when our photo-Roentgen units were obtained, many operating conveniences had been developed and were incorporated in these units. Our procedure had been well established in large centers and we had details of the program in Cleveland, Chicago and other areas. In our hospitals, the photo-Roentgen unit provides two stereoscopic 4 x 5 films, which are developed in special hangars, read in a 4 x 10 stereoscope and then filed in a separate special file. We have separate 200 MA transformers powering rotating anode tubes, with exposure controlled by a Morgan timer.

The need for a program of this type probably cannot be accurately measured—but statistics show that over 15,000,000 persons enter a general hospital every year, and if all of these were examined, it would reach the largest group other than industrial, and as a whole would reach a different cross section of the people, as the greater proportion of these individuals would not have had an industrial survey. Many people entering the hospital are more susceptible to tuberculous infection because of inroads on their resistance by other pathological changes.

Because of the limited financial stature of many hospital employees, and their close contact with the patients, it is perhaps more important that they be checked upon employment and again routinely, than in some other industries which now regularly require chest studies.

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It is also highly important that a tuberculous individual does not contaminate non-tuberculous patients during their hospital sojourn. These are a few of many good reasons that justify the need for this type of examination.

The procedure is not particularly costly. In some institutions under optimum circumstances, the per patient cost is as low as 25 cents. In our institutions, we suspect that the per patient cost lies between 60 and 65 cents. *All* of these studies are stereoscopic 4 x 5 films and the film cost at least could be cut in half by not obtaining a stereoscopic study (which we definitely like better, but which does not appear to be a necessity.) Other types of photo-Roentgen procedure are considerably cheaper, but become more difficult to the radiologist. In Decatur & Macon County Hospital, we refer to this study as "P.R. Chest" (photo-roentgen chest) and *not* routine chest. The term "Routine" is reserved for a 14 x 17 two meter study at 500 MA technique, which is obtained on suspected patients.

The greatest single impediment to us, is getting the patient to the x-ray department. Many times, especially at the beginning of the enterprise, the "admission" films became the "before discharge" films; and in other instances, the accident patient or otherwise incapacitated patient on admission, was discharged after hours or over the weekend and no film was obtained.

Upon arrival, the patient's admission slip for the x-ray department is numbered to correspond with the number that will appear on the film, the patient is then positioned and a photoroentgen stereoscopic exposure is made. The patients are then returned to their room and development is done later on the same day at a time convenient to the darkroom technician. The usual time consumed per patient is between one-half and one minute. When dried, the films are read in groups, usually once per day and an on the spot report completed by checkmarking the findings on a printed form. This

photo-roentgen film does not provide a diagnosis, but a "suspicion of". The printed form or report includes three suspicions, which are as follows; "positive - advise routine roentgenogram," (meaning a 14 x 17 film), or "suspect possible tuberculosis," with various forms of TB listed, or "suspect a non-tuberculous lesion," with a listing of cardiae, bronchitis, pneumonia, pleural effusion, neoplasm, etc. If the lesion suspected is tuberculous, an additional report is sent directly to the tuberculosis sanatorium for Dr. Loewen's records and follow-up. This is not done in the films that we believe are not suggestive of tuberculosis. The film is then recorded numerically and a report is filed alphabetically on a small file card. If a patient is re-examined at a subsequent date, the same card is used and the additional films are filed together in the same envelope. At the end of each month a summary of the case examined is sent to the Macon County Visiting Nurse & Tuberculosis Association group—broken down into three classifications, tuberculous, non-tuberculous and negative.

This survey has been carried out in many larger cities and with larger groups, than we observe in this section of the State, and many areas are probably much more efficient than are we, and also have been functioning longer, permitting an opportunity to establish a more smoothly operating set-up. These larger groups report about as high as 3% positive tuberculous cases. Necessarily this 3% is a potent factor in the spread of tuberculosis, and should be discovered and properly segregated as indicated for their own welfare and that of those persons with whom they come in contact.

In Macon County, photo-roentgen case finding was begun on June 2, 1947 at Decatur & Macon County and St. Mary's Hospitals as a coordinated program of the local tuberculosis assoeiation. In the period between June 2, 1947 and March 24, 1950 (at which time this portion of the report was obtained), 8,588 photo-fluorograms were obtained — 3,729 at St. Mary's and 4,859 at Decatur & Macon County Hospitals. Of this group, 75 were suspected of tuberculosis at St. Mary's and 124 at Decatur & Macon County, for a total of 199, of which 165 were referred to the sanatorium. Out of these 165, 66 were studied — 2 cases proved active; 12 were known inactive cases and no further study was made; 25 were not eligible for follow-up as their residences were out of Macon County; 62 that were referred were not followed as they were uncooperative; and 34 cases were never referred to the sanatorium.

In this period of time, there were 3 minimal active tuberculous cases with negative sputum in St. Mary's Hospital and 1 in Decatur & Macon County. There were 4 moderately advaneed cases in St. Mary's and 2 in Decatur & Macon County. Of these 6, 4 presented positive sputum and 2 negative. There were 7 far advanced cases at St. Mary's and 5 at Decatur & Macon County—all of which had positive sputum. Six cases were missed; 2 minimal at St. Mary's and 1 at Decatur & Macon County; 1 moderately advanced and 2 far advanced cases at St. Mary's none at Decatur & Macon County. Three of these had positive sputum, which is dangerous when unknown, as proper protection can be utilized to avoid infection. One of these cases was reported after a State bus film was made, but the attending physician seemed unaware of the condition, and the patient was in a general hospital for three weeks as a cardiac patient before this danger was corrected.

In addition, 3 moderately advanced and 10 far advanced cases were found on large films, which had been ordered immediately by the referring physician because of chest symptoms. Five of these cases, all far advanced, were not previously known. Eight of this group — 3 moderately advanced and 5 far advanced, were known by their physician and the tuberculosis sanatorium as active tuberculosis prior to admission. One case of minimal tuberculosis was accidentally found while looking for a substernal thyroid gland.

In passing, for the sake of the record, there were 6 active extrapulmonary lesions, all with negative sputum, as follows — 2 pleural effusions, 1 tuberculosis of the kidney, 1 tuberculous peritonitis and 1 tuberculous meningitis.

In conclusion: — photo-fluorography as a routine procedure in general hospitals, though not widely established is no longer in an experimental stage.

It provides a vast source of individuals, who will not be examined under other circumstances, and when discovery of an active unknown case is

made before too many people have been exposed too long, its value is probably immeasurable.

We are examining about 50% of those admitted to the hospital, the other 50% are equally as important and as the percent examined approaches 100, so proportionately does its relative efficiency. We are of the opinion this per cent can be increased sharply by a re-location of the photo-fluorographic unit as close to the admission office as possible, with the procedure taking place immediately before the patient is transferred to his or her room. This necessarily cannot occur in some cases because of the nature of the illness or accident injury.

These photo-roentgen studies also have been the first film to indicate lesions other than tuberculosis, such as pathological cardiac findings, non-tuberculous lesions, neoplasms and other miscellaneous conditions which we have not attempted to enumerate.

While photo-fluoroscopy in a general hospital may provide an occasional organizational headache, it merits full support of all concerned — patient, doctor, nurse, hospital management — as frequently it is more important to more people than other commonly accepted routine laboratory procedures.

Early tuberculosis, like early carcinoma, usually responds favorably, while in advanced stages it may be too late, but tuberculosis is preventable; and increasing impetus in this field of endeavor can produce fruitful and gratifying results.

Decatur & Macon County Hospital

## ALCOHOLISM

We must learn more about the psychology of the alcoholic. We must test different therapies for alcoholism under controlled conditions and gather more data. We must try to find, if we can, what effect the treatment has on the psychology of the patient. We must examine without bias all treatment approaches presented on a rational basis or in which some claims for success have been made. We must not, however, think that we know, as yet, why a given treatment fails or succeeds. Lengthy follow-up studies are necessary and, if possible, we must try to follow those patients whom we study for periods of two to ten years. One of our greatest problems at present is to get the funds necessary to make such research feasible. The problem is expensive to the individual and to the community. Research would cost far less than is spent on alcoholic beverages by drinkers. Alcoholism is a serious medical problem. It is a serious social problem. It is more baffling than almost any other problem in psychiatry. *Excerpt: Alcoholism, Problems of Treatment and Research, Allen J. Enelow, M.D., Topeka, Kans., Rocky Mountain Med. J., Sept.,* 1950.

# CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

# Tuberculosis of the Acromioclavicular Joint With Subscapular Bursitis and Effusion

**Samuel J. Taub, M.D., F.A.C.P., Irving A. Friedman, M.D., and J. Birney Dibble, M.D.**
**Chicago**

The incidence of tuberculous involvement of the joints and bursae of the shoulder has been reported frequently, especially in the subdeltoid[1,5] and sub-trochanteric bursae.[2,6] However, only few references have been made to tuberculosis of the acromio-clavicular joint.[3,1] We have recently observed an interesting case of acromioclavicular tuberculosis with subscapular bursitis and effusion in a patient with Laennec's cirrhosis. It is believed that this case is worthy of presentation because of the unusual clinical course.

The patient, M.K., age 51, white male, entered Cook County Hospital on September 1, 1949 with the complaint of ankle and abdominal swelling for three weeks which receded after resting and increased on walking. During this period he had been troubled with a persistent cough productive of small amounts of greenish sputum, weight loss, constipation associated with bright red blood occasionally mixed with the stool, and definitely diminished urinary output. The color of his urine became dark red-brown over a period of three weeks, and he gave a vague history of night sweats for the past three years.

*Past History*: He had "spinal meningitis" in 1929 with complete recovery, and the left clavicle was fractured four years ago with good union. Alcoholic history consisted of heavy drinking since 1921 including a daily intake of four glasses of wine, twenty glasses of beer and occasional whiskey. The past five months before admission his intake of alcohol included twenty glasses of beer plus several "shots" of whiskey daily.

*Physical Examination*: The patient was a fairly well developed white male who appeared malnourished. The abdomen was greatly distended and the legs were markedly edematous. He was intelligent and cooperative. The blood

From the Medical Service of Dr. Samuel J. Taub, Cook County Hospital, Chicago, Illinois

pressure was 140/100, temperature 100° F, pulse 98 per minute, respiration 22 per minute. The sclerae appeared slightly icertic and the fundi were normal. His tongue was beefy red and there was obvious cheilitis. Auscultation of the chest revealed noisy respiration with inspiratory and expiratory wheezes in all areas. Heart borders were normal and there were no murmurs heard. Ascites was present and the liver could be palpated six fingers below the costal margin. The spleen was not palpable. Rectal and proctoscopic examination showed small internal hemorrhoids.

*Laboratory Data*: On admission the hemogram showed 67% hemoglobin, 3.43 million erythrocytes, 11,300 leukocytes with 78% polymorphonuclear leucocytes, 15% lymphocytes, 7% monocytes. Urinalysis revealed a trace of albumin and 4 plus urobilinogen; but no sugar or abnormal microscopic findings. Serology; agglutinations for typhoid, salmonella, and brucella; and sputum examinations for acid-fast bacilli were negative. Non-protein nitrogen was 22 mgm. percent. total proteins 6.7 grams percent with albumin 3.1 grams and globulin 3.6 grams, cephalin flocculation 3 plus, thymol turbidity 7.7 units, cholesterol 102 mgm percent, alkaline phosphatase 1.6 units, icterus index of 14. The BSP test gave 30.3% retention and the prothrombin determination was 88 percent. Original chest film revealed blunting of the costophrenic angles and thickening of the interlobar fissure on the left. Complete upper and lower gastro-intestinal X-ray examination with barium sulfate was normal.

*Course in Hospital*: The patient was placed on a low salt, high protein, high carbohydrate diet, with brewer's yeast tablets, vitamin A, C, D, thiamin intramuscularly, and mercurial diuretics. The ascites increased as did the leg edema. He had a persistent temperature of 100 to 102 degrees Fahrenheit, and had a deep hacking cough with moderate dyspnea. 100 units of Penecillin was given every 3 hours without effect, and on September 27, he was started on Steptomycin, two grams daily. Despite mercurials, the ascites became very marked so that it was necessary to perform a paracentesis on September 29, 1949 at which time almost three gallons of clear yellow fluid with a specific gravity of 1018 and 1.5 grams of protein per 100 cc of fluid was obtained. Routine and acid-fast cultures on this material were negative. On October 1, 1949, dullness and rales were noted in the right lung base, and a chest film showed right lower lobe pneumonitis. This condition cleared very rapidly, and the temperature slowly dropped to normal.

On October 4, 1949, the patient passed tarry stools, felt weak and the blood pressure dropped to 110/70. Several blood transfusions were given and the bleeding ceased. The dyspnea slowly subsided, and the streptomycin as well as the liver regime including methionine and choline was continued. Repeated liver function tests were essentially the same as on admission. On October 27, 1949, left pleural effusion was found on examination and chest film. However, the patient remained afebrile and the leg edema subsided slowly. It was necessary to perform a paracentesis about every two weeks because of marked abdominal distension and subsequent dyspnea. Several cultures of the ascitic fluid for tubercle bacilli were done and found to be negative. Mantoux tests done in dilutions of 1:1000 and 1:10,000 were negative. The left pleural effusion persisted although the appetite was good. Frequent urine examinations revealed 1 plus

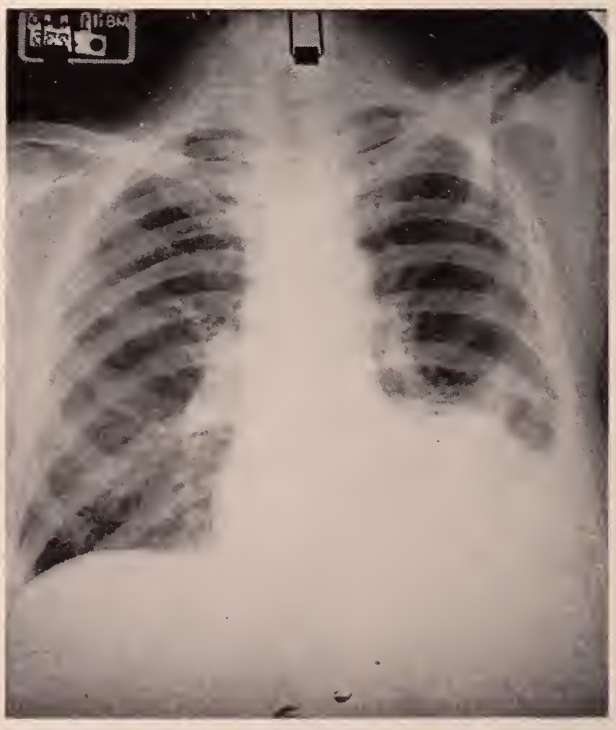


**Figure 1. PA view of chest showing left pleural effusion**



**Figure 2. PA view of chest showing increased density in right lower lung field in region of subscapular mass.**

urobilinogen but no bile. Mercurials seemed to have no effect on the ascites but reduced leg edema.

On the evening of January 20, 1950, the patient noted a fluctuant mass under the right scapula, which seemed to get larger over night to the size of a small football. This mass remained the same for 5 days, when aspiration was performed and about 150 cc of thick amber fluid with 4.4 grams of protein per 100 cc was obtained. The cystic area quickly refilled, and at this time it was noted that as the ascites progressed the subscapular mass receded. When it was necessary to tap the abdomen, an astonishing observation was made in that the subscapular mass rapidly became larger. At first this seemed to be only coincidental, but on three successive episodes of tapping the abdomen and observing the cystic back mass as the abdominal fluid accumulated, the same inverse relationship was observed, namely, enlargement of the cystic subscapular mass when fluid was removed from the abdomen and recession as the ascites again appeared. On February 14, 1950, after paracentisis, 30 cc of sterile methylene blue solution was placed in the peritoneal cavity. The next day, as was expected, the subscapular mass was very prominent, and aspiration revealed the same thick amber fluid. It did not gel and had a specific gravity of 1020 with proteins of 5.1 grams per 100 cc. Papanicalou smear was negative, but culture for acid-fast organisms revealed definite tubercle bacilli. X-ray of the right acromio-clavicular joint showed destructive changes. The chest surgery consultant suggested the diagnosis of subscapular bursitis with effusion secondary to acromioclavicular pathology. Aspiration of the right acromioclavicular joint gave 1 cc of thick bloody material which gave a negative culture. The patient was again placed on streptomycin for ninety days with very little change. When seen in August of 1950, the subscapular mass had receded somewhat, but his general condition was about the same.



**Figure 3. Side view of patient showing subscapular mass and ascites.**




**Figure 4. X-ray of acromioclavicular joint showing destructive changes.**

*Discussion*: Although tuberculous bursitis has been reported frequently especially in the subdeltoid and subtrochanteric areas, we believe this case to be of especial interest because of the marked subscapular effusion and the patient's clinical course. Many diagnoses were offered for this case before the cultures returned, including a cyst in this area, fistula from the pleural cavity with fluid migration, and hematoma, all of which were easily ruled out. The most interesting and peculiar aspect to the many attending men and residents who saw this case was the relation of the mass in the subscapular region to the ascites as described above. Of course, the culture of the fluid for acid-fast organisms was of utmost importance, and although the ascitic fluid cultures were negative, and thoracentesis was never done, it is believed that the patient had tuberculous pleural effusion, tuberculous peritonitis as well as the subscapular bursitis. We have not been able to explain the dynamics of the variation in the size of the subscapular mass depending on the degree of ascites present. We also believe the subscapular tuberculous effusion may be connected with the acromio-clavicular tuberculosis.

*Summary*: A case of Laennec's; cirrhosis with tuberculous subscapular bursitis and effusion is presented, possibly associated with acromioclavicular joint involvement. An interesting and confusing phenomenon of change in the size of the subscapular cystic mass depending on the degree of ascites was observed, but could not be explained.

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# PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



## PRESENTATION OF THREE CASES

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### SACCULAR ANEURYSM OF THE LEFT VENTRICLE OF THE HEART FOLLOWING CORONARY OCCLUSION.

This white male, aged 53 years, entered St. Luke's Hospital in the care of Doctor Walter Hoeppner on February 19, 1950 with a history of having had two previous attacks of coronary occlusion. The first had been ten years, and the second four years before his admission to the hospital. The second attack was associated with marked ventricular tachycardia from which he recovered promptly. His activities, however, were restricted because of the cardiac condition. At 6 P.M. on the day of admission he had a sudden attack of pain in the chest with radiation to the left shoulder, and associated with tachycardia. He was given morphine and sent to the hospital. His blood pressure was 120/80 mms. Hg; his pulse was 160 per minute; his heart tones were rapid and faint. The blood had 22,500 leucocytes and 5,020,000 erythrocytes per cu. mm. The nonprotein nitrogen of the blood was 47.5 mgms. and the cholesterol 365 mgms. per cent. The urine had a large quantity of albumin. The leucocytes remained elevated. The sedimentation rate rose from 9 mms. on the first day to 51 mms. in one hour on the fifth day. The electrocardiogram disclosed ventricular tachycardia. The patient received anticoagulants, quinidine, and supportive therapy but his blood pressure dropped to 80/60 mms. Hg. on the first day. There were transient reversals to normal rhythm of the heart, rales appeared in the chest, the heart rate continued to fluctuate, the blood pressure was unstable, and on the eighth day the patient died suddenly.

The essential portions of the anatomic diagnosis of the necropsy (trunk) are:

Atherosclerotic occlusion of the anterior descending branch of the left coronary artery of the heart;

Old healed infarct and hypertrophy of the myocardium of the left ventricle of the heart;

Large calcified aneurysm with mural throm-

bosis of the lateral wall and septum of the left ventricle of the heart;

Chronic adhesive fibrous pericarditis;

Chronic passive hyperemia of the liver, spleen, kidneys, and lungs; etc.

The heart had the changes which were directly related with the illness of the patient. The pericardial sac was adherent to the anterior surface of the left ventricle in a region 4 cms. in diameter. The markedly enlarged heart with 2 cms. each of aorta and pulmonary artery weighed 800 gms. The pulmonary veins and artery had smooth linings. The leaflets of the pulmonic valve were thin, the circumference of the ring was 10 cms. The right ventricle from the attachment of the pulmonic leaflets to the apex was 14.5 cms. and from the tricuspid ring to the apex it was 13 cms. The myocardium of the right ventricle near the septum in front had a thickness of 7 mms. and there were 2 mms. of subepicardial fat. There was only a remnant of Eustachian valve and the foramen ovale was closed. The circumference of the tricuspid ring under slight tension was 15 cms., the leaflets were thin. The lining of the right auricle, the right auricular appendage and of the right ventricle was smooth. The lining of the left auricle and of the left auricular appendage was also smooth. The columnae carneae and papillary muscles of the left ventricle were hypertrophied and the cavum was dilated. Under slight tension the circumference of the mitral ring was 13 cms. The leaflets of the mitral valve had slight fibrous and fatty changes. In the anterior wall of the left ventricle and encroaching on the septum was a large, saccular aneurysm 7 by 5 cms, 2 cms, deep and with a large red-brown mural thrombus. The deeper portions of the thrombus contained semi-liquid brown blood material and portions of the fibrous wall of the aneurysm were calcified (Figure 1). The length of the left ventricle from the mitral ring to the apex was 11.5 cms. and from the attachment of the aortic leaflets to the apex it was 12 cms. The circumference of the aortic ring under slight tension was 6.5 cms. The leaflets were thin. The sinuses of Valsalva were deep and the mouth of each coronary artery was widely patent. There was a small accessory right coronary artery. The root and arch of the aorta had marked atherosclerosis. The myocardium of the left ventricle measured along the septum

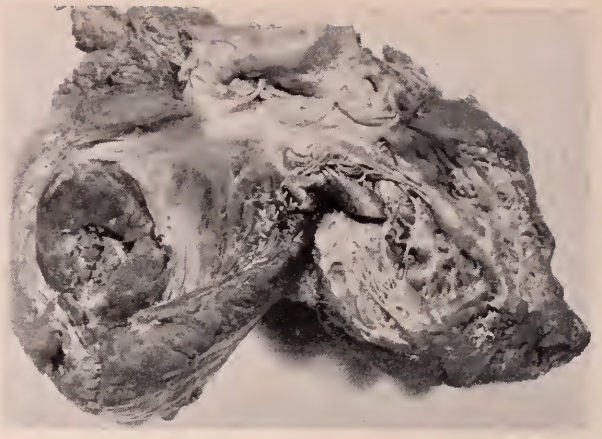


**Figure 1. Photograph illustrated the saccular thrombosed aneurysm of the left ventricle of the heart.**

behind at the mitral ring level was 1.8 cms. thick, near the apex it was 2.2 and between it was 2 cms. Surfaces made by cutting the septal myocardium away from the aneurysm were tan-brown fibrillar tissue. Surfaces made by cutting the lateral wall of the left ventricle had toward the apex a large fibrous scar continuous into other calcified fibrous tissues. The right coronary artery had a moderate atherosclerosis of its lining but the lumen was widely patent. The anterior descending branch of the left coronary artery had marked atherosclerosis and at a level 2.5 cms. from its origin the channel was practically occluded by an atheromatous plaque with hemorrhage. The circumflex branch of the left coronary artery also had a marked atherosclerosis but its lumen was patent. The changes in the viscera otherwise were essentially those of a chronic passive hyperemia. The lungs had a hypostatic bronchopneumonia. Histological preparations of the myocardium near the aneurysm were scar tissue. Adjacent muscle tissue were necrotic and infiltrated by polynuclear leucocytes, histologic evidence of recent infarction.

## COMMENT

The effect of a coronary occlusion is essentially a diminished blood flow to the tissues beyond the arterial lesion. The amount of decreased blood flow determines the extent of the subsequent necrosis of the myocardium and replacement of the contractile muscle by scar tissues. Within limits, fibrous scar tissue replacement of the infarct occurs without a localized dilatation of the ventricle chamber but infarcts of larger size, during or after the healing phase, become aneurysmal. The pouch fills with laminated thrombus

material which tends to become organized or may soften into semiliquid material. Huge aneurysms near the apex of the left ventricle have cast shadows in roentgen films of patients which were diagnosed as a thoracic tumor. Hearts with considerable generalized atherosclerosis of the coronary arteries have severe interference of blood supply and, in addition to fibrous scars there is atrophy of the muscle with decrease in the thickness of the ventricle wall, and atrophy of the papillary muscles and columna carneae. The muscle function, of course, is decreased. Cognizance of such sequellae with coronary disease enables a better evaluation of the clinical symptoms in these patients.

## ACUTE NEPHROSIS IN AN INFANT

A white male child, aged 28 months, entered St. Luke's Hospital in the care of Doctor C. Stepan on March 11, 1950 and died on the same day. He had been a patient in the clinic because of spastic paraplegia and when seen on March 8th seemed to be in good health. He developed a cold, had vomited for 24 hours before admission, and had received only crystacillin as medication on March 10th and March 11th. The child was dehydrated and appeared severely ill. His respirations were shallow and he died shortly after reaching the children's ward. Urine collected immediately after death contained 200 mgms. per cent albumin and many red blood cells. The clinical diagnosis was acute glomerulonephritis.

The important portions of the anatomic diagnosis of the complete necropsy are:

Acute glomerulonephritis (lipoid nephrosis) of the kidneys;

Hyperemia, edema and focal hemorrhages of the lungs;

Fatty changes of the liver;

Cloudy swelling of the myocardium and parenchymatous tissues.

The body weighed 29 pounds. The serous cavities of the trunk had smooth moist surfaces but no collections of fluid. The pericardium had a slight excess of fluid with a few grey floccules. The lining of the trachea and bronchi was hyperemic. The hyperemic, edematous, subcrepitant right lung weighed 90 gms., the similar left lung 80 gms. The heart weighed 50 gms. There were no significant changes of the valves or myocardium. The large pale right kidney weighed 58 gms., the left 60 gms. The capsule of the kidneys stripped from a hyperemic tan-yellow surface, smooth except for fetal lobation markings. The pale yellow cortex was 8 mms. wide and the height of the corresponding pyramid was 15 mms. The columns of Bertini ranged to 4 mms. The lining of each renal pelvis and ureter was smooth (Figure 2). The biliary lymph nodes were large. The pancreas weighed

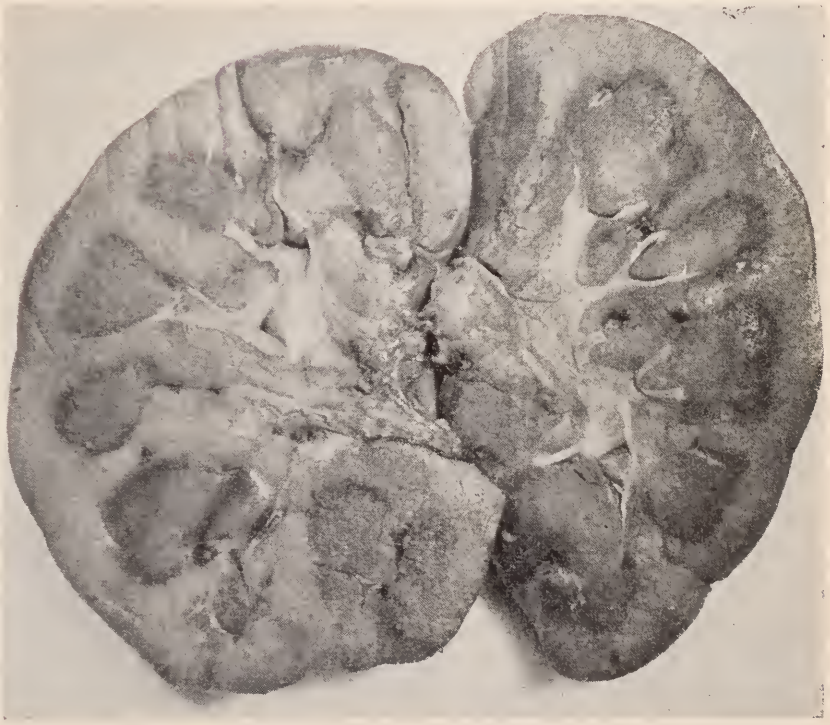


**Figure 2. Photograph illustrating the nephrosis of the kidney.**

20 gms., the spleen 70 gms., and the liver 310 gms. The capsule of the liver was smooth and the tissues beneath were tan-yellow and had some lobular markings. The lining of the oesophagus, stomach, bowel, colon and rectum had no changes. The brain weighed 1100 gms. and when examined after formalin solution fixation had nothing unusual. Histologically the glomerular tufts of the kidneys were vascular and moderately cellular. There were marked changes of the tubular epithelium. The lining cells of the convoluted tubules were pale, granular and swollen, the lumens contained granular precipitates. In sections stained with Sudan the tubule cells had large amounts of lipid material. The liver also had marked deposits of lipid.

COMMENT

The history of the illness of this child is short. With the exception of the absence of edema, the anatomic changes observed in the body are those of a so-called lipoid nephrosis. This is not a sharply defined kidney disturbance but rather merges into the proliferative form of glomerulonephritis. The urine of the child had a large amount of albumin and numerous red blood cells indicating an increased permeability of the glomerular capillaries. Histologically the glomerular tufts had dilated capillaries and only a slight increase in cells. The sections stained with Sudan demonstrated large amounts of lipid material in the renal tubules and the fatty changes of the liver indicated a marked systemic metabolic disturbance. This form of kidney disease occurs in childhood and adolescence. Had the illness not terminated so quickly in this child, the other clinical manifestations such as anasarca would have developed, and studies of the blood would have disclosed decreased plasma proteins and a reversal of the albumin-globulin ratio.

## OSTEITIS DEFORMANS (PAGET'S DISEASE) WITH OSTEOGENIC SARCOMA OF THE SPINE

A white male aged 49 years entered St. Luke's Hospital for the second time on February 2, 1950. His first admission was to the service of Dr. Eric Oldberg in July of 1949. He was a native of Greece and came to Chicago because of pain in the lower thoracic region of the back which had been present for about four months. In his native land this had been treated as a tuberculous lesion. A month before admission the pain became severe and he was forced to rest in bed. During this rest, weakness developed in the right leg and difficulty in walking. He was a well-nourished, middle-aged male with weakness in all movements of the right leg and hyperesthesia below the level of the first lumbar vetrebra. A spinal puncture disclosed a block and the fluid contained 820 mgms. per cent of protein. An x-ray examination of the spine demonstrated a destructive process of the tenth thoracic vertebra, and changes in the last lumbar vertebra and the left side of the sacrum had some of the features of Paget's disease or those of a metastatic cancerous growth. A myelogram located the obstruction at the level of the tenth thoracic vertebra. He had mild anemia. Other laboratory tests revealed no significant information. Doctor Oldberg explored the spine and performed a lower dorsal laminectomy with decompression of the spinal cord. Bone tissues removed at the time of operation were diagnosed as osteitis deformans (Paget's disease) of the spine. Two days after the operation he had complete loss of voluntary control of the lower extremities and urinary retention. Then a more extensive laminectomy was done. Nineteen days later he was explored again. He had remained paraplegic, had some loss of sensation bilaterally in the groin, and a loss of sphincter control. A cord block was shown to be present at the level of the eighth and ninth thoracic vertebrae. The laminectomy, accordingly, was extended upward to these levels and tissues removed at the time of this operation were found to contain osteogenic sarcoma and osteitis deformans. He remained in the hospital for 181 days and returned on February 2, 1950 without improvement of symptoms and with dyspnea of about ten days' duration. When examined he was paraplegic. The left side of the chest was dull to percussion to the level of the sixth thoracic vertebra. The right chest was clear to auscultation and percussion. The blood had 3,780,000 red cells and 10,250 leucocytes per cu. mm. The urine contained 90 mgms. per cent of albumin, many leucocytes and variable numbers of erythrocytes. The alkaline phosphatase was 29.25 mgms per cent and a roentgen film of the chest revealed a large collection of fluid on the left side. A liter of bloody fluid

was aspirated. An indwelling catheter was placed in the urinary bladder to facilitate drainage. On the third hospital day another 800 cc. of bloody fluid were removed from the left side of the chest but other attempts at aspiration met with difficulty in introducing the needle and gave the inpression of tumor tissues on the left side. The patient received nitrogen mustard therapy and had a severe attack of dyspnea and tachycardia. He died on April 1, 1950.

The essentials of the anatomic diagnosis of the necropsy (trunk) are:

Osteogenic sarcoma of the 10th, 11th and 12th thoracic vertebrae of the spine;

Sarcoma invasion of the spinal segment of the 10th, 11th, and 12th right and left ribs, the sternal end of the left 5th rib, the sternum, the right and left lung and pleura, the thoracic periaortic tissues, the pericardium, and the second lumbar vertebra;

Extensive old laminectomy and exploratory scar of the back;

Osteogenic sarcoma compression of the azygos veins, the thoracic duct and the intrapulmonary branches of the pulmonary artery and veins;

Marked compression atelectasis of the left lung;

Bilateral hemothorax;

Hyperemia and edema of the right lung;

Bilateral obliterative fibrous pleuritis;

Disuse atrophy of the lower extremities;

Chronic passive hyperemia and fatty changes of the liver;

Chronic passive hyperemia of the spleen; etc.

The body of this adult white man weighed 180 pounds. There was marked atrophy of the lower extremities. On the inner surface of the left ankle was a decubitus ulcer 2.5 cms. in dia., another was on the inner surface of the right heel, 4 cms. in dia. and a third over the right hip was 5 by 7 cms. The peritoneal structures had no significant changes. On the left side of the visceral surface of the sternum was a mass of osteoid tissue, some of it hard and some of it soft, which extended from above down 10 cms. and was 4.5 cms. wide. Portions of these tissues were in nodules as large as 1 cm. Most of the right pleural space was obliterated by adhesions between the lung and the chest. The left pleural space was obliterated by fibrous adhesions between the lung and the chest and in the interstices were collections of bloody fluid. The left lung was markedly compressed. The heart had no significant changes. The pericardium posteriorly was invaded by sarcoma tissues. Evisceration of the chest and abdomen exposed a huge growth of hard and soft tumor tissue on the left

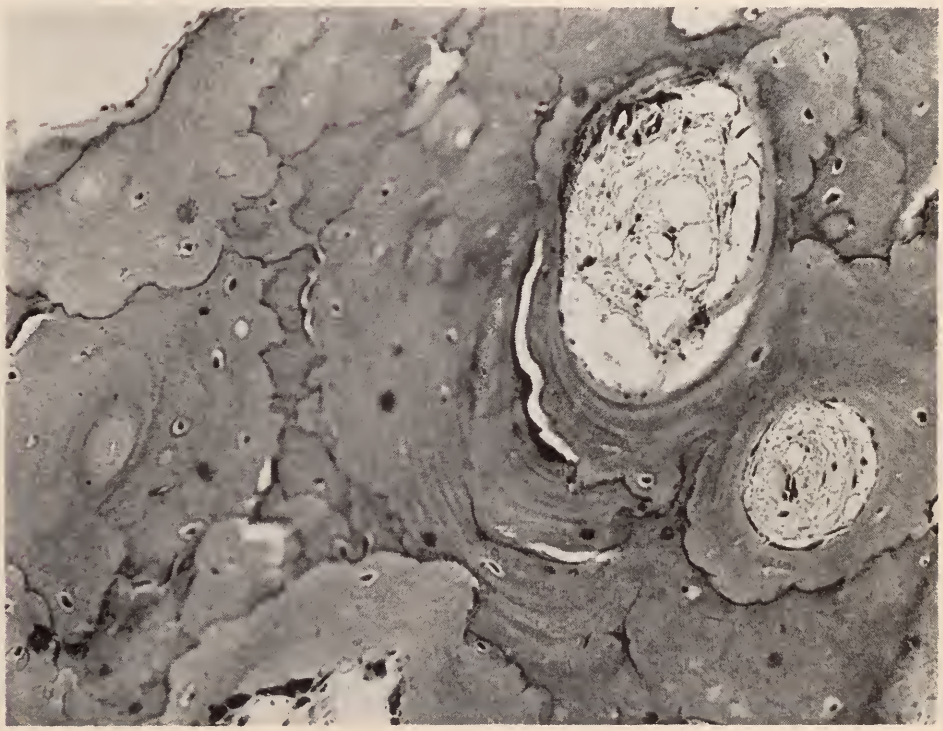


**Figure 3. Photomicrograph illustrating the mosaics of lamellar tissue in bones with Paget's disease. X-198**



Figure 4. (above) Photograph illustrating the osteogenic sarcoma of the thoracic portion of the spine.

side of the spine that began at the level of the clavicle, extended to the 11th thoracic vertebra and spread laterally 6 to 8 cms. The tissues cut with resistance. On the right side of the spine opposite the 10th, 11th and 12th thoracic vertebrae was another mass of hard tissue, 8 cms. long, 5 cms. wide and 4.5 cms. thick. These tissues were partially ossified. Many single and confluent tumor nodules were under the left and right parietal pleura. The 12th to the 5th thoracic vertebrae were completely replaced by grey tumor tissue. The lumbar spine had no tumor tissue except the second vertebra which had a small wedge of grey tissue. Grey tumor tissues from the spine extended into the ribs as much as 3 cms. The first left rib at its sternal articulation was grey with porous tumor tissues. The upper portion of the aorta on the left side and behind was encased by tumor. Just above the diaphragm on the right side was a pocket 10 to 15 cms. in diameter filled with fibrin and blood which displaced the lung upward. The markedly consolidated right lung with multiple nodules weighed 895 grams. The pleura was covered with round button-like grey-red tumor nodules that cut with the resistance of medullary bone. In the parenchymal tissues were many hard bone-like nodules of tumor. The markedly collapsed left



Figure 5. Photograph illustrating the osteogenic sarcoma invasion of the left first rib and also of the parietal pleura.



**Figure 6. Photograph illustrating the sarcoma nodules in the right lung.**

lung weighed 360 grams, and had nodules of bony tumor tissues 1 to 2.5 cms. in diameter. Surfaces made by cutting this lung had several hard tumor nodules 1 to 3.5 cms. in diameter. The suprarenal glands, the kidneys, the liver, the spleen, the pancreas, the gastro-intestinal tract, urinary bladder, prostate, seminal vesicles and testes had no tumor tissues. Tumor tissues from many places had a fibrillar stroma and a large amount of osteoid tissue arranged in trabeculae. The soft portions of the tumor had a fibrillar stroma with numerous atypical pleomorphic mesoblastic cells, round, oval or spindle shaped, and with vesicular nuclei. There were also bizarre giant cell forms with corresponding nuclei or with hyperchromatic irregularly lobed nuclei. Many cells were in mitosis.

## COMMENT

Paget mentioned the tendency of patients with osteitis deformans (Paget's disease) to develop sarcoma, and the occurrence of sarcoma with this disease, according to many reports, is more than a mere coincidence. The relationship is strengthened also by the presence of osteogenic tissues in a large number of the sarcomas described. Some writers think the sarcoma with osteitis deformans has structural features which differ from the usual osteogenic sarcoma. Sarcoma develops more frequently in males with the disease than females. The long bones and the cranium are most frequently affected. The occurrence of sarcoma in the spine (vertebra) is rare. This report, therefore, describes sarcoma with Paget's disease originating in an uncommon portion of the skeleton.



**Figure 7. Photograph illustrating the sarcoma invasion of the right parietal and visceral pleura.**

# NEWS OF THE STATE



## CHAMPAIGN

**Society News.**—Dr. H. Kent Tenney, Jr., professor of pediatrics, University of Wisconsin School of Medicine, Madison, addressed the Champaign County Medical Society, November 9, on "The Responsibility of the General Practitioner in the Emotional Problems of Children." Dr. Manuel Lichtenstein, Chicago, addressed the October meeting of the society on "Failure of Gallbladder Surgery." Dr. Richard Young, dean of the Northwestern University Medical School, recently discussed "The Future in Medical and Dental Education" before the society.

## COLES

**Fifty Year Pin.**—Dr. C. E. Greer was inducted into the Fifty Year Club of the Illinois State Medical Society at a recent meeting of the Coles County Medical Society. The presentation was made by Dr. Harlan English, Danville. Similar insignias were given to Drs. Ed Summers and C. B. Voigt of Mattoon.

## COOK

**Personal.**—Dr. Loyal Davis, professor of surgery and chairman of the department, Northwestern University Medical School, has been elected a regent of the American College of Surgeons, it was announced November 10. He has also been named director of the Franklin H. Martin Memorial Foundation which publishes the medical journal, "Surgery, Gynecology and Obstetrics."—Dr. Charles D. Krause, instructor in obstetrics and gynecology, University of Illinois College of Medicine, addressed the medical students at the Escuela de Medicina de Nuevo Leon, Monterrey, Mexico, during a meeting November 27-29. His subjects were "Obstetrical Emergencies and Their Treatment" and "Adenomycosis Symptoms and Treatment." While there, he addressed the local Association of Obstetrics and Gynecology on "Ectopic Pregnancy."—Dr. B. Barker Beeson, Chicago, has been elected an honorary member of the Societe Francaise de Prophylaxie Sanitaire et Morale and also of the Societe de Therapeutique, both of Paris.—Dr. Bernard G. Sarnat, clinical assistant professor of oral surgery, University of Illinois College of Medicine, has been named the recipient of the second prize in the 1950 international essay competition for the Kerbs Award in Plastic Surgery. The Kerbs award is offered by the Foundation of the American Society of Plastic and Reconstructive Surgery for an essay on an original unpublished research, basic or clinical, in plastic surgery. The title of Dr. Sarnat's paper was "The Effect of Surgical Removal of the Condyle on the Growing Mandible: An Experimental Study on the Macaca Rhesus Monkey." The paper was presented November 29 at the annual meeting of the American Society of Plastic and Reconstructive Surgery held jointly with plastic surgeons of Central and South America at Mexico City.

**Society News.**—The Chicago Heart Association held a clinical section, November 10, at Wesley Memorial Hospital, with the following physicians participating: Drs. Frederic A. Lestina, David E. Markson and Paul S. Rhoads, on "Effect of ACTH on Lupus Erythematosus"; Dr. Charles E. Thompson, "Paroxysmal Hypertension Occurring in a Patient with Spinal Cord Injury"; Drs. George C. Sutton and George E. Wendel on "An Evaluation of Intracardiac Angiocardiography"; and Dr. Clayton J. Lundy, "Clinical: Pathologic Problems." Dr. Joseph F. Mallach presided.—Dr. Edward F. Rosenberg, chief of the arthritis clinics, Michael Reese and Mount Sinai Hospitals, and assistant professor

of medicine, Chicago Medical School, addressed the Chicago Society of Physical Medicine and Rehabilitation, November 22, on "Use of Cortisone and ACTH in the Treatment of Arthritis: Its Relationship to Physical Medicine."—Dr. Louis B. Newman, chief, physical medicine and rehabilitation service, Veterans Administration Hospital, Hines, was guest speaker recently in conjunction with the three-day Institute on Geriatric Nursing which was sponsored by the Loyola University department of nursing, Chicago. Dr. Newman gave an illustrated talk on "Physical Medicine and Rehabilitation of the Disabled."—The Chicago Rheumatism Society was addressed October 25 by Dr. Evan M. Barton, Chicago, on "Experiences with Cortisone in Long-standing Crippling Disease."

**Branch Meetings.**—Dr. C. W. Mayo, Rochester, Minnesota, discussed "Diagnosis and Management of Lesions of the Rectosigmoid" before the North Suburban Branch of the Chicago Medical Society, October 9. The Branch was addressed November 13 by Dr. Smith Freeman on "Physiology and Therapeutic Indications of ACTH and Cortisone."—At a meeting of the Northwest Branch November 3, Dr. Herbert E. Schmitz spoke on "Bleeding in the Climacteric."

**The Julius Hess Memorial Lecture.**—Dr. Robert Gross, Ladd professor of children's surgery, Harvard Medical School, Boston, gave the Julius Hess Memorial Lecture, October 18, at the University of Illinois College of Medicine on "Surgery in the Early Months of Life."

**The Pusey Memorial Lecture.**—Dr. George W. Pickering, director, medical unit, St. Mary's Hospital, London, England, gave an illustrated lecture on "Headache", October 30, at a joint meeting of the Institute of Medicine of Chicago and the Chicago Society of Internal Medicine. The presentation was the Fourth William Allen Pusey Memorial Lecture of the Institute.

**Lectures by Dr. Snapper.**—Dr. I Snapper, director of medical education of Mount Sinai Hospital, New York City, gave two lectures in Chicago November 8-9, at Mount Sinai Hospital, Chicago, on "Metabolic Aspects of Multiple Myeloma" and "The Influence of Customs on Disease in Tropical Areas."

**Community Health Forum.**—The Tuberculosis Institute of Chicago and Cook County sponsored a community health forum, November 15-16, at the Metropolitan Community Church, Chicago. The session was divided into the following discussions: The Function of the Tuberculosis Association in Tuberculosis Control, The Function of the Official Agency in Tuberculosis Control, Tuberculosis: A Community Problem, and Community Participation in Tuberculosis Control.

**Dr. Nalefski Named Clinic Director.**—Dr. Lester Nalefski has been named medical director of the Montgomery Ward Clinic of Northwestern University's Medical School, it was announced recently by the University.

As clinic medical director, Dr. Nalefski will supervise clinical work by senior medical students and direct administration of the clinic. His work will be under supervision of Dean Richard H. Young and Medical School department heads.

Dr. Nalefski, member of the Medical School's Department of Medicine since 1949, has done extensive research on heart disease. He has published 16 articles dealing with the disease, work of the heart, and cardiac metabolism.

In addition to serving as Clinical Medical Director, he will continue his teaching research duties in the Department of Medicine. Prior to joining the Medical School staff, he served as senior medical resident at St. Luke's Hospital in Chicago and as a Captain in the Army Medical Corps.

**Grants in Aid.**—Dr. Piero P. Foa, department of physiology and pharmacology, Chicago Medical School, has been awarded a grant in the amount of $3,339 by the U. S. Public Health Service. This grant has been given for the continuation of his work on the study of the utilization of vitamins in diabetes.—A grant in the amount of $3,000 from the White Laboratories of Newark, New Jersey, has been made to the Chicago Medical School, to be used for cardiovascular research, and will be administered by Dr. Aldo A. Luisada, director of the program of cardiology at the school. Armour and Company has awarded a $3,000 grant to the School for research on the splenic hormone principle. The grant will be used by Dr. George A. Scheff, department of microbiology and public health.—Northwestern University Medical School has received a grant of $1,625 from Airkem, Inc. of New York, for olfactory research under the direction of Dr. Jules H. Masserman, associate professor of nervous and mental diseases. Dr. Masserman's work deals with the olfactory component of neurosis and the influence and effect of smell upon individual reactions and impressions. Major part of the research study is being conducted with cats and monkeys in an attempt to determine general reactions produced by certain odors. The $1,625 gift is part of a $6,500 yearly grant given to Northwestern by the national corporation.

**Clinical Conference of Ophthalmological Society.**—The Chicago Ophthalmological Society will hold its Third Clinical Conference, at the Edgewater Beach Hotel, February 15-17, 1951. Registration will be at the hotel. Clinics are being planned at the various Chicago hospitals, the schedules for which will be available at registration. On Friday, the following speakers will participate: Drs. Peter C. Kronfeld and Joseph S. Haas, "Glaucoma"; Dr. Harold Scheie, Philadelphia, "Goniotomy and Goniopuncture"; Dr. Paul Greeley, "General Principles of Plastic Surgery" and Dr. Irving S. Puntenney, "Plastic Surgery of the Eye." On Saturday, Dr. Derrick Vail will serve as moderator on a symposium on "Recent Advances in Ocular Therapeutics." In the afternoon, the speakers will be Dr. Robert

Masters, Indianapolis, on "Ocular Injuries" and Dr. J. V. Cassady, "Dacryocystitis of Infancy." In the evening, Dr. Alan C. Woods, Baltimore, will deliver the Seventh Annual Sanford R. Clifford Lecture on "The Present Status of the Adreno-Cortical Hormone in Ophthalmology."

For additional information, write to Miss Maud Fairbairn, 8 West Oak Street, Chicago 10. Registration fee: $25.00, payable at time of registration.

**Surgical Society Annual Prize.**—The Chicago Surgical Society awards an annual prize of $250 for a manuscript describing experimental work in experimental or clinical surgery. The paper submitted must represent the original work done by one aided by associates but not necessarily based on a completely original idea; the illustrations must be original and not borrowed from someone's correlated work; the paper must never have been read or printed anywhere as submitted in its final form; the diction and simplicity of the presentation must remain a large factor in its value; all references to the literature or other sources of information cited must be in orthodox fashion, conforming to type of abbreviations and order used by the Quarterly Cumulative Index Medicus; all illustrations must have ample legends appended, and proper and sufficient identification marks should be indicated to make understanding of the illustrations clear and easy; resident requirements of applicants should be made to conform to those required for possible members in the Chicago Surgical Society, as expressed in its Constitution and By-Laws, viz., Cook County, Illinois; all identification marks of the individual and of the hospital or institution in which work was performed must be eliminated. The paper, accompanied with a sealed envelope bearing the title of the paper and containing the name and address of the author, should be in the hands of the secretary, Dr. Harvey S. Allen, 154 East Erie St., Chicago 11, not later than March 15, 1951.

**Foundation for Retarded Children.**—The Dr. Julian D. Levinson Memorial Foundation, established in September to aid mentally retarded children, held its first public meeting in October. Speakers included Dr. Abraham Levinson, chief of the children's department of Cook County Hospital and professor of pediatrics at Northwestern University Medical School. The foundation is named for his son, a pediatrician, who died last June at the age of 27. Dr. Karl A. Meyer, medical superintendent of Cook County Hospital, and Dr. Samuel J. Hoffmann, administrative director of the Hektoen Institute for Medical Research, with which the foundation is affiliated, spoke at the meeting.

**New Affiliation to Establish Residency Training Program.**—An affiliation has been consummated between St. Francis Hospital of Peoria and the University of Illinois College of Medicine for the purpose of establishing a residency training program in surgery.

The affiliation is expected to be mutually beneficial to both institutions. The staff of St. Francis will be augmented by the appointment of qualified physicians who have received one or two years of surgical experience at the University's Research and Educational Hospitals in Chicago.

The plan will enable the University to train a larger number of qualified surgeons, and to give them a more diversified teaching program. In the three-year training program for resident surgeons, they will receive instruction at a teaching institution as well as at a private community hospital.

Dean Stanley W. Olson of the College of Medicine has announced that Dr. Charles D. Branch, chief of surgery at St. Francis Hospital, has been appointed to the faculty of the University. He will supervise the St. Francis phase of the cooperative program.

Dr. Branch has been appointed with rank of clinical assistant professor of surgery. A graduate of the University of Michigan, Dr. Branch was a member of the faculty of Harvard Medical School prior to his appointment at St. Francis in 1945.

**Course for Stutterers and Their Families.**—Northwestern University is preparing to institute a special evening course on its Chicago campus for adult stutterers, Dr. Harold Westlake, professor of speech correction, announced recently.

Assistance and counsel will be provided not only for people who stutter but also for members of their families. Dr. Westlake pointed out that it is important for the family as well as the stutterer to have a thorough understanding of this type of faulty speech.

"When parents, or the husband of wife of a stutterer show undue concern, the victim senses this anxiety and often feels rejected," the Northwestern professor explained. "This condition make it more difficult for the stutterer to overcome his speech defect."

The Northwestern course, called "Speech for Stutterers," will be conducted by Philip Hood, staff member of the University's Speech and Hearing Clinic. Instruction will be given every Tuesday night from 6:20 to 8 p.m. for 18 weeks, beginning February 5. Classes will be held in the Montgomery Ward building at 301-303 E. Chicago Ave. Registration will be held from Jan. 27 through Feb. 3 on the fifth floor of Wieboldt Hall, 339 E. Chicago Ave.

The class work will include lectures on the causes and nature of stuttering, discussions of problems faced by stutterers and their families, and practical demonstrations of techniques for controlling stuttering. The course will not be academic but will deal with the problems of the class members. The Northwestern University Speech and Hearing Clinic was one of the first university clinics of this type established in this country. Since its beginning in 1926, it has pioneered in research, training speech and hearing therapists, and in clinical work with persons having speech problems. At present, the clinic staff includes eight faculty members and 18

clinical workers. The clinic program is conducted in cooperation with Northwestern's Medical School and the School of Dentistry.

### CUMBERLAND

**Personal.**—Dr. R. C. Steck, Toledo, has been named superintendent of Anna State Hospital, Anna, to succeed Dr. C. D. Nobles, who will retire December 31, it was announced in Springfield recently.

### FRANKLIN

**Personal.**—Dr. Charles Henry Eldridge has left the active practice of medicine and gone to Harlingen, Texas.

### FULTON

**Society News.**—Dr. H. D. Junkin, Paris, discussed "External Fixation of Fractures" before the Fulton County Medical Society, October 26, in Canton.

### HANCOCK

**Carthage Hospital Dedicated.**—The sixth Illinois hospital has been completed under the federal and state hospital construction acts—the 46-bed Carthage Memorial Hospital. This hospital recently had the honor of being named the "Modern Hospital of the Month" by the magazine, Modern Hospital. Dedication ceremonies featured an address by Dr. Malcomb T. MacEachern, Chicago.

### KNOX

**Society News.**—Dr. Armand J. Mauzey, Chicago, recently addressed the Knox County Medical Society, in Galesburg, on "Diagnosis and Treatment of Ectopic Pregnancy." At the same meeting, Senator Wallace Thompson gave a brief presentation on "The Gateway Amendment to the Constitution of the State of Illinois."

### LAKE

**Hospital News.**—An addition to the Highland Park Hospital was dedicated October 8 with special ceremonies. Representatives of all denominations of the county participated in the observance as well as the members of the medical staff of the hospital, members of the woman's auxiliary, and the Lake County Medical Society.

### MASON

**Dr. Steele Day.**—Residents of Havana publicly honored Dr. William A. Steele on his eighty-third birthday, November 11. Mayor Clarence Chester gave the official proclamation naming the day as "Dr. Steele Day." A public parade opened the celebration with all local groups participating. Harry Nesmith, national surgeon general of the Amvets, and Dr. Harlan English, Danville, representing the Illinois State Medical Society, acclaimed Dr. Steele's medical service of the last fifty-four years. Some time was spent in Carmi, Chicago, and the last forty-one years in Havana.

### MC DONOUGH

**Society Election.**—Dr. B. H. Borum, Blandinsville, was elected president of the McDonough County Medical Society, October 27. Other officers elected were Dr. O. A. Dively, first vice president; Dr. R. L. Franck, second vice president; and Dr. R. C. Benkendorf, secretary-treasurer. Dr. R. F. Millet was elected delegate and Dr. V. B. Adams, alternate, to the Illinois State Medical Society. Dr. W. E. Carnahan was chosen necrologist, Dr. C. L. Weston, chosen to the membership committee for three years, and Dr. Millet, board of censors for three years. At the meeting, Dr. C. N. Stephens, Industry, was presented with the Fifty Year Insignia indicating membership in the Fifty Year Club of the Illinois State Medical Society. The presentation was made by Dr. Charles P. Blair, Monmouth, Councilor of the District. Dr. Arkell M. Vaughn, Chicago, addressed the meeting on "Surgical Treatment of Varicose Veins."

### PEORIA

**Personal.**—Dr. R. L. Eddington, Lacon, was presented with the Fifty Year Insignia of the Illinois State Medical Society at a meeting of the Peoria Medical Society.

### PERRY

**Personal.**—Dr. Gilbert H. Edwards, Pinckneyville, has been named a member of the advisory board of cancer control. The appointment was made by Governor Adlai Stevenson.

### ROCK ISLAND

**Society News.**—At the November 14 meeting of the Rock Island County Medical Society in Moline, the speakers were Dr. Austin Smith, editor of the Journal of the American Medical Association, and Dr. E. R. Serles, dean of pharmacy of the University of Illinois. Their subject was "Interprofessionally Yours."

### SANGAMON

**Dr. Baxter Named to New Post.**—Dr. A. C. Baxter, formerly State health officer, has been appointed city superintendent of health of Springfield. The position has just been placed on a full-time basis. Dr. J. H. Shamel, who has held the position for more than three years in a part-time basis, resigned.

**Society News.**—The Sangamon County Medical Society was addressed November 2 in Springfield by Dr. Grant H. Laing on "Problems of Amebiasis" and Dr. Guy V. Pontius on "Surgery of Gastric Peptic Ulcer." Dr. Paul C. Bucy addressed the society, October 5, on "Management of Convulsive Disorders." The speakers are all of Chicago.

### WHITESIDE

**Personal.**—Dr. John D. Hollander, who has practiced in Morrison for the past four and a half years, left November 2 for Ripon, California, his home town, where he will practice. Dr. W. W. Robinson, who has been practicing with his brother, Dr. S. E. Robinson of Prophetstown, will assume Dr. Hollander's practice.

## WINNEBAGO

**Society News.**—Dr. Jan H. Tillisch, Rochester, Minnesota, addressed the Winnebago County Medical Society, November 14, in Rockford, on "Postoperative Medical Complications."

## GENERAL

**Surgeons to Hold Seven Sectional Meetings.**—The first of a series of seven Sectional Meetings of Surgeons will be held in St. Louis on January 22 and 23, with headquarters at the Hotel Statler, according to an announcement by Dr. Henry W. Cave of New York, President. Attendance will be largely from Arkansas, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, North and South Dakota, and Wisconsin, although there is no geographic restriction. The other six Sectional Meetings will be held in Hot Springs, Virginia, February 26 and 27; Philadelphia, March 5 and 6; New Haven, March 16 and 17; Portland, Oregon, March 26 and 27; Denver, April 6 and 7 and Detroit, May 10 and 11. The Sectional Meeting will open at 8:30 both mornings with the showing of medical motion pictures. On the first morning these will be followed at 10:00 o'clock by a scientific session with the following subjects: "Surgery for Ischemic Diseases," "The Emergency Management of the Injured Chest," "Fractures about the Ankle Joint," and "Hermaturia Following Trauma: Present Means of Diagnosis and Treatment."

Luncheon will be held on the first day followed by medical motion pictures at 1:30. The panel discussions on the first afternoon will be on "Neck Surgery" and "Acute and Chronic Osteomyelitis."

On the first evening a dinner for Fellows and other members of the medical profession will be held, following which there will be discussion of activities of the College and a talk on "The Medical Organization of the Chinese Communists" by Dr. Melvin A. Casberg, Dean, St. Louis University Medical School. From 8:30 to 10:00 there will be a Symposium on Cancer.

On the second morning from 8:30 to 10:00 there will be a showing of medical motion pictures, and also presentation of papers on trauma, arranged by the Committee on Trauma. From 10:00 to 12:00 o'clock there will be a scientific session on the following subjects: "Varicose Veins — Stripping versus Ligation," "Special Problems in the Surgical Treatment of Ulcerative Colitis," "Personality Functioning and Ulcerative Colitis" and "Carcinoma of the Stomach."

Following the luncheon period there will be a showing of medical motion pictures from 1:30 to 2:00. From 2:00 to 3:30 there will be a panel discussion of "Emergencies Arising During Operation" and from 3:35 to 5:00 on "Proper Relationship Between Patient, Physician, Consultant and Hospital."

On the day following the Sectional Meeting in St. Louis, January 24, a full day of clinics will be held in St. Louis hospitals for the visiting surgeons.

## DEATHS

Julius S. Alexander, Peoria, who graduated at Illinois Medical College in 1909, died August 19, aged 64. He was a member of the American Psychiatric Association and affiliated with Peoria State Hospital.

Annie Belle Alguire, retired, Belvidere, who graduated at Medical Faculty of Trinity University, Toronto, Canada, in 1895, died October 8, aged 82. She was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Harry Bernard Bernhardt, who graduated at Northwesten University Medical School in 1909, died August 15, aged 65, of myocardial infarction.

Joseph J. Ehresmann, retired, formerly of Carrollton, who graduated at St. Louis University School of Medicine, died October 20, aged 73.

Clinton J. Estes, Harrisburg, who graduated at Chicago College of Medicine and Surgery in 1915, died October 24, aged 65.

Fred S. O'Hara, retired, Springfield, who graduated at Marion-Sims College of Medicine, St. Louis, in 1899, died October 1, aged 74. He was a member of the "Fifty Year Club" of the Illinois State Medical Society and the first president of the Radiological Society of North America.

Josephine Estabrook Young, retired, Evanston, who graduated at Northwestern University Women's Medical School in 1896, died October 4, aged 84.

# "FOR THE COMMON GOOD"

**Health Talk Moves to Evening Time on WGN-TV.**—Beginning November 1, Health Talk, the weekly telecast produced by the Educational Committee of the Illinois State Medical Society in cooperation with WGN-TV, was moved to Wednesday night at 9 p.m. The series observed its second anniversary on WGN-TV, December 15. **Television Forecast,** the weekly trade magazine, featured Health Talk in a recent issue with illustrations and a story of the highlights of the history of the series which has been presented as a public service.

That the telecast is being used as a teaching instrument is reflected in the inquiries and comments coming from biology students in the Chicago area; some have been received from Waukegan. The Radio Council of the Chicago Board of Education recently asked permission to view a program in the studio while it was being televised. Health Talk is on the list of recommended telecasts by the Council.

Among the "firsts" the series has established was the first public telecast of an actual living beating heart; this was coupled with a reproduction of the sounds of the heart by means of a special amplifier. "Guardians of Your Sleep" was another first, demonstrating the administration of anesthesia; this telecast was selected by the Council of the Illinois State Medical Society to be presented in Columbus, Ohio, in May as a pioneer feature of the Annual Institute of Education by Radio. "Preparing the Surgical Patient", another first, revealed the techniques used in removing bacteria, the draping of the patient, administration of anesthesia and surgical techniques. So realistic was this program that many viewers called to ask whether an operation had been performed.

Since the last issue of the Illinois Medical Journal, the following telecasts have been presented:

Home Care of the Sick Child, October 23, C. Edward Stepan.

"Guardians of Your Sleep" (repeat), Max Sadove, James H. Cross, Lloyd Gittelson. Edward Pelikan, and Nurse Lenore K. Hermann, November 1.

"You and Tuberculosis", Jerome Head, November 8.

"Congenital Club Foot", Manley Page, November 15.

**"Your Doctor Speaks"** over WFJL, Thursday evenings, at 7:30 carried the following transcribed broadcasts under the auspices of the Educational Committee.

C. Wesley Eisele, November 2, Human Diseases Transmitted by Animals.

Edwin Hirsch, November 9, Why An Autopsy.

Maurice H. Cottle, November 16, Plastic Surgery.

John R. Wolff, November 23, Prenatal Care.

**"You and Your Baby"** over Station WAAF, Tuesday mornings at 10:30 a.m. presented the following physicians in live broadcasts: under the auspices of the Educational Committee:

Arthur W. Fleming, October 24, The Young Explorer

Arthur Rosenblum, October 31, What First—Mind or Body?

So popular was this series that the Station asked to repeat it. The same physicians and the same scripts are being used in the repeat broadcasts:

George Vlasis, November 7, Prenatal Care.

Charles D. Krause, November 14, Instructions to the Mother as Time of Delivery Approaches.

**"Here is Your Doctor"** over Station WCFL, Saturday mornings at 11 a.m. presented the following physicians in transcribed broadcasts under the auspices of the Educational Committee:

Jules H. Masserman, November 4, Mental Hygiene Under the Threat of War.

Geza de Takats, November 11, Varicose Veins.

Richard Bennett, November 18, Hernias.

**Lectures Arranged Through the Educational Committee:**

Louis R. Limarzi, Industrial Nurses Section, First District, Illinois State Nurses Association, September 14, on Diagnosis and Treatment of Common Blood Disorders.

Frank Deneen, Bloomington, Clinton Business and Professional Women's Club, September 28, on "Advances in Medicine."

Adrian D. M. Kraus, Park Manor PTA, November 8, on Foundations for Better Health and Physical Fitness.

Robert R. Mustell, Salvation Army Hospital and Clinics, November 8, on Colds.

Young Mothers' Club of Bryn Mawr Community Church, November 18, on My Child Will Not Eat.

Lars E. Lundgroot, Marshall PTA, November 15, on Basic Concepts of Child Development.

Edward A. Piszczek, Forest Park, St. John's Methodist Episcopal Church, November 16, on Health in A Rural Community.

Morris Friedell, Hyde Park YMCA Men's Club, November 28, on Superstitions About Health.

Samuel B. Broder, Gresham Woman's Club, November 29, on Your Mental Health.

Lawrence Breslow, Sauganash PTA, January 9, on Health of Grade School Children.

Helen B. Carlson, Lincoln Park Business and Professional Women's Club, January 10, on Behind the Rose Colored Glasses.

Paul K. Anthony, Bowen PTA, January 16, on Understanding the Adolescent.

Frank G. Murphy, Chicago, Paul Revere PTA, January 17, on Know Your Feet.

Joseph T. O'Neill, Ottawa, Greeley School

PTA, January 18, on Better Health and Physical Fitness of the Citizen Child.

Carl H. Hamann, Rockford, Junior Matrons of the Ottawa Woman's Club, January 19, on "The Balanced Budget in Mental Health."

Earl E. Eilson, Oak Park, Benjamin Franklin PTA in Glen Ellyn, January 22, on Understanding the Mental Health of Your Child.

Mrs. Kris Peterson, assistant in public relations, American Medical Association, January 26, on Petticoats in Public Relations.

**Lectures Arranged by the Scientific Service Committee:**

L. Martin Hardy, Chicago, Morgan County Medical Society, in Jacksonville, November 9, on Use of Antibiotics in the Common Diseases of Children.

Frederick Steigmann, Chicago, Henry County Medical Society in Kewanee, November 9, on Jaundice.

James H. Hutton, Whiteside-Lee County Medical Societies in Rock Falls, December 7, on Office Procedures in the Diagnosis and Treatment of Endoctrinopathies.

Morley D. McNeal, Highland Park, Bureau County Medical Society, Spring Valley, December 12, on Problems in Infant Feeding.

Herbert E. Schmitz, La Salle County Medical Society in La Salle, January 11, on Indications for Cesarean Section.

**Postgraduate Conferences:** The following postgraduate conferences were arranged for the indicated Councilor Districts:

**First,** embracing the counties Boone, Carroll, DeKalb, Jo Daviess, Kane, Lake, McHenry, Ogle, Stephenson and Winnebago in Freeport, November 29, with the Stephenson County Medical Society acting as host and with Joseph Lundholm, Rockford, Councilor, presiding: The following all participated:

Irving E. Steck, Arthritis and Allied Conditions, illustrated.

Howard L. Alt, Present Day Treatment of the Common Blood Diseases.

Robert M. Grier, Evanston, Importance of Clinical Observations of the Last Month of Pregnancy.

Hugh A. Flack, Cardiovascular Diseases.

Arthur H. Rosenblum, Gastrointestinal Allergies in Infants.

Harold M. Camp, Monmouth, Voluntary Prepaid Medical Insurance.

Anthony V. Partipilo, Duodenal Obstruction.

**Fifth District,** embracing the counties of DeWitt, Logan, Mason, McLean, Menard, Montgomery, Sangamon and Tazewell, in Pekin November 9, with the Tazewell County Medical Society acting as host and Ralph P. Peairs, Normal, Councilor presiding. The following program was presented:

Edwin F. Hirsch, Chicago, and James Weimer, Pekin, Clinical Pathological Conference.

Raphael Isaacs, Recent Advances in Diagnosis and Treatment of Leukemia and Anemia.

William F. Lauten, Burns.

Edwin N. Irons, Use and Abuse of ACTH in a Small Hospital.

James H. Hutton, Office Procedure in Diagnosis and Treatment of Endocrinopathies.

Harold M. Camp, Monmouth, Voluntary Prepaid Medical Insurance.

Warren H. Cole, Intestinal Obstruction.

**Seventh District,** embracing the counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt and Shelby in Effingham, November 30, with the Effingham County Medical Society acting as host and with Plina A. Adams, Altamont, president of the society, presiding: The participants included:

Harry A. Oberhelman, Relationship of Chronic Cystic Mastitis to Cancer of the Breast.

Willard O. Thompson, Clinical Uses of ACTH and Cortisone.

Philip Lewin, Backaches and the Disc Syndromes.

Henry Buxbaum, Management of Occiput Posterior.

Fremont A. Chandler, Management of Fractures of Both Bones of Forearm.

Walter M. Whitaker, Quincy, Present Day Treatment of Rheumatic Fever.

Harry M. Hedge, Office Dermatology.

Jacob E. Reisch, Springfield, Voluntary Prepaid Medical Insurance.

Morris Parker, Differential Diagnosis of Medical and Surgical Jaundice.

**Eleventh District,** including the counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall and Will in Elmhurst, November 15, with the DuPage County Medical Society acting as host and Edwin F. Neckermann, Elmhurst, president of the society, presiding. Speakers were:

Harry A. Oberhelman, Indications for Surgery in Peptic Ulcer.

Clayton J. Lundy, Anticoagulants in Heart Disease.

Norris J. Heckel, Chronic Pyelitis.

Rollin T. Woodyatt, Diabetes in Childhood.

Mr. John W. Neal, Voluntary Prepaid Medical Insurance.

Smith Freeman, Metabolism and Clinical Effects of ACTH and Cortisone.

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## 'ESKACILLIN-SULFAS'

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'Eskacillin-Sulfas' is for the prevention and treatment of infections caused by organisms sensitive to the action of penicillin or the sulfonamides.

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It is an easy-to-take fluid—available in 2 fl. oz. bottles.

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# COMFORT IN A RIM..



Rim of a "RAMSES" Diaphragm exposed showing coil spring completely encased in cushion of soft gum rubber.

A coil spring with the necessary tension to hold it firmly against the vaginal walls can produce discomfort unless it is properly cushioned. Examine the rim of the "RAMSES"* Diaphragm and you will find that the coil spring is encased in soft rubber tubing, which acts as a protective cushion. This construction is patented and available only in the "RAMSES" Flexible Cushioned Diaphragm.

# PROTECTION IN A DOME..




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A diaphragm dome must not only occlude the cervix—it must have a reasonably long life. The exclusive process used in manufacturing the dome of the "RAMSES" Diaphragm from pure gum rubber produces velvet smoothness, plus flexibility and long life.

A comparison will quickly reveal the advantages of supplying the patient with the patented "RAMSES" Flexible Cushioned Diaphragm.

"RAMSES" Diaphragms are available in sizes ranging from 50 to 95 millimeters in gradations of 5 millimeters.

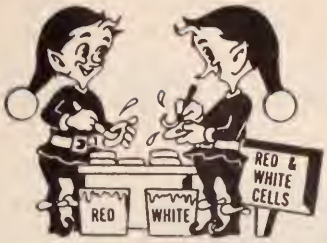
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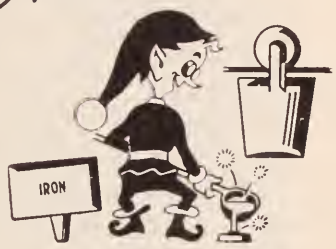
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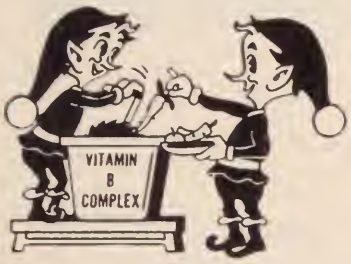
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**QUESTION:** *How many red blood cells are replaced due to "wear and tear"?*

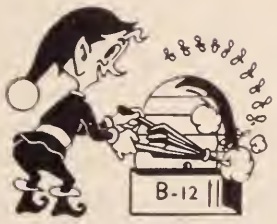
**ANSWER:** *Approximately 25 million a day in normal people*




When abnormal demands overtax the blood forming capacity of the body producing easy fatigability, sub-clinical anemia too often does not receive corrective treatment until more serious symptoms urgently demand attention.

Frequently more than just iron deficiency is involved. The patient does not respond to simple iron therapy and other factors must be added.




Livitamin, "the first thought in hypochromic anemias," combines liver with iron and B complex vitamins, including vitamin $B_{12}$. Available as a palatable liquid or easily swallowed capsules, Livitamin provides a complete approach to the successful treatment of the hypochromic anemia syndrome.




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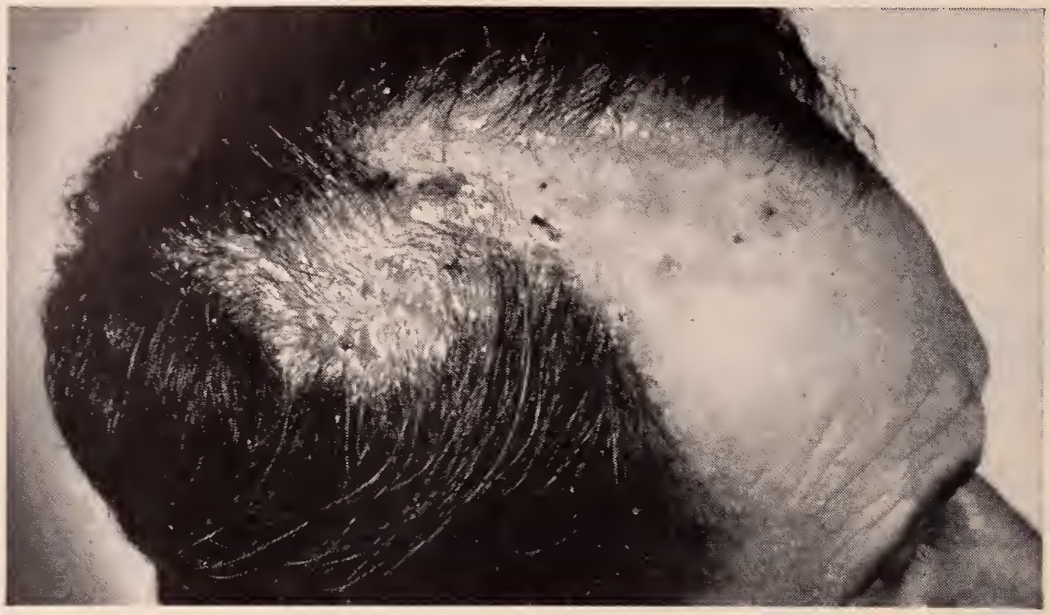
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In the control of dandruff and in the general care of the seborrheic scalp, few preparations have proved as effective as Pragmatar—the outstanding tar-sulfur-salicylic acid ointment.

Pragmatar is also valuable in infants' "cradle cap"; in eczematous eruptions of the scalp, particularly those with a seborrheic component; and in seborrheic psoriasis of the scalp.

Pragmatar's superior oil-in-water emulsion base was specially developed for use on hairy surfaces. Pragmatar is non-gummy and non-staining; easy to apply and easy to remove.

# PRAGMATAR

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# *Chemically Standardized Veratrum Viride Is Effective in Hypertension*

Much has been written pro and con about the value of veratrum viride in hypertension. For many years the drug has been in disrepute because of the fact that the preparations available on the market have been prepared by "hit or miss" methods.

Chemical standardization of veratrum viride, however, has provided in this drug a highly effective agent for the treatment of hypertensive patients.

Sollmann[1] states that veratrum is probably the most active and reliable cardiac depressant and that its use serves to slow and soften the pulse and lower the blood pressure.

Willson & Smith[2] state that veratrum viride possesses a vasodilating effect and because of this, it was demonstrated by Hite,[3] and Freis and Stanton,[4] that the drug lowered pressure in hypertension and gave symptomatic relief. Recent research tends to show that the decrease in blood pressure results more from peripheral vasodilation than from depression of cardiac output.

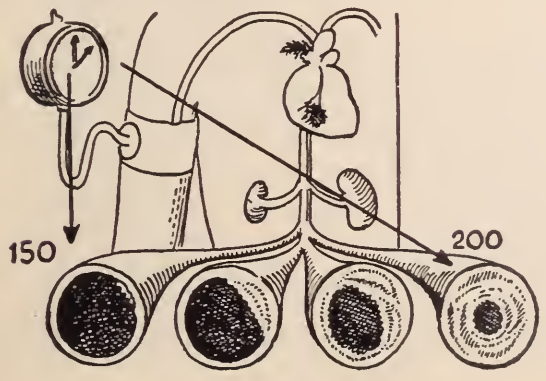
### *Uniformity of Action*

When the veratrum alkaloids are chemically standardized, a uniform result can be expected. Their action usually causes a reflex fall in blood pressure and heart rate which originates in the afferent vagus nerve endings in the myocardium of the left ventricle and in the lungs. Although these factors ordinarily result with each heart beat, the veratrum alkaloids cause them to act continuously over prolonged periods of time. Reports have shown that 80 to 90 per cent of hypertensive patients respond to therapy when chemically standardized veratrum viride is used.

### *Cardio-Vascular Symptoms Cleared*

In addition to the lowered pressure, objective signs of improvement may be observed, such as the clearing of retinal hemorrhages; diminution in cardiac size and reversal of left ventricular strain patterns in electrocardiograms.

Accompanying symptoms of the cardiac-hypertension syndrome, such as exertional dyspnea, tachycardia, nervous irritability, headache, are relieved. Yet, while the results of veratrum viride medication are prolonged, the drug may not afford quick relief.




### *Role of the Nitrites*

For prompt and effective fall in blood pressure, nitroglycerin, which acts in one to two minutes, is the drug of choice. It acts rapidly and, because of its powerful vasodilatory action, gives the patient almost immediate relief. The action of nitroglycerin, however, is fleeting and to sustain lowered pressure between the action of nitroglycerin and veratrum viride, an intermediate is necessary.

To this end, sodium nitrite is used. This drug is also a vasodilator and affords sustaining relief until the long range action of chemically standardized veratrum viride becomes effective.

### *Importance of Sedation*

Nearly all cases of hypertension require sedation for allaying periods of anxiety and affording the patient a good night's rest. Mild sedation is often useful, especially in cases associated with chronic coronary insufficiency.[5] It is well known that excitement may induce anginal attacks and in such cases, phenobarbital, because of its prolonged action, should be used.

All of these drugs, chemically standardized veratrum viride, nitroglycerin, sodium nitrite, and phenobarbital are to be found in Capsules RAY-TROTE IMPROVED, prepared by the Raymer Pharmacal Company of Philadelphia, Pa. Each capsule contains

| | |
|---|---|
| Phenobarbital | 15 mg. |
| Sodium Nitrite | 30 mg. |
| Nitroglycerin | 0.25 mg. |

With the equivalent of Veratrum Viride Tincture 4 minims (containing 0.1% alkaloids)

RAY-TROTE IMPROVED is effective in dosages of one capsule every three hours. It is contraindicated when renal insufficiency is present, or if pulse becomes abnormally slow following treatment.

For the 30% of hypertensive patients with capillary fault, the above formula, with 20 mg. of Rutin added, is available in RAY-TROTE with Rutin.

*Bibliography*

1. Sollmann: A Manual of Pharmacology, W. B. Saunders Co. (1942).
2. Willson & Smith: J. Pharmacol., 79:208 (1943).
3. Hite: Ill. M. J., 90:336 (1946).
4. Freis & Stanton: Am. Heart J., 36:723 (1948).
5. Falk: South. M. J., 40:501 (1947).

Send for a liberal clinical supply of RAY-TROTE IMPROVED Capsules and descriptive literature today to Raymer Pharmacal Company, N.E. Cor. Jasper and Willard Streets, Philadelphia 34, Pa.

# PHYSICAL MEDICINE ABSTRACTS



## SHELTERED WORKSHOPS

George G. Deaver, M.D., New York, N.Y. In THE CRIPPLED CHILD, 28:17, June 1950.

Rehabilitation of more than twenty-three million disabled persons is one of the major problems which our nation must solve. Congenital defects, accidents and disease have been the chief causes of physical disabilities. But our aging population is now contributing the largest percentage of disabled persons.

As many of these individuals as possible must be restored to their maximum physical, emotional, social and educational capabilities so that they may become independent of the help of others, or at least be placed in a vocation best suited to their abilities and disabilities. The essential factor to consider for most handicapped persons is their physical capabilities.

In considering job placement for the disabled the following factors must be considered. Has maximum physical rehabilitation been attained? Can this person travel to a job by the usual means of transportation and care for his daily needs while at work? Would it be possible to train him to perform these activities essential for daily living and working?

The vocational guidance counsellor must classify the disabled person as to his ability to walk and travel, care for his daily needs, the use of his hands and ability to speak. With the aid of these facts, vocational possibilities can be prognosticated.

The sheltered workshop is one aspect of our work program which must receive greater emphasis. It is the place for work reconditioning and the proving ground where a final evaluation of the person's work potentiality can be made. Here therapy can be provided in a work program while the handicapped person is paid for receiving treatment. In planning a sheltered workshop, however, it is essential first of all to decide the purpose of the program, as there are many types of workshops.

There are two improper ways of conducting a sheltered workshop—ways which indicate less concern with the handicapped than with impressive production records. One of these is to select only those patients who have enough physical ability to turn out large volumes of work, enabling the workshop to fulfill contracts efficiently. The other improper approach is to retain handicapped persons who have acquired enough skill to go out into industry, but are kept in the workshop to bolster production records. The more efficient the workers become, the greater the desire is to keep them.

The ideal sheltered workshop for those handicapped by congenital defects, disease or trauma, who are in need of physical rehabilitation to meet

(*Continued on page* 48)

# TERRABON*

*Brand of* TERRAMYCIN ELIXIR

*Trade Mark

## equivalence



1 teaspoonful (5cc.) of TERRABON* Brand of Terramycin Elixir

one 250 mg. capsule of Terramycin Hydrochloride

## assures

broad-spectrum antibiotic activity without unwieldy dosage schedules.

Patients who experience difficulty in taking the customary forms of oral antibiotic medication will respond eagerly to the

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***the only broad-spectrum antibiotic available as an elixir***

*Available at prescription pharmacies in bottles containing 1 fl. oz.*

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*Antibiotic Division*

CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

the demands of daily living and working and the opportunity to gain skill and speed in productive employment best suited to their abilities and disabilities, required the following equipment and personnel:

(1) Sufficient space for a sheltered workshop and rehabilitation units which have facilities and personnel to teach the disabled person how to work and meet his physical deficiencies in walking, climbing, self-care, better use of the hands and speech.

(2) A Consultant physician to evaluate each person's disabilities and formulate his program.

(3) The rehabilitation units must have qualified physical and occupational therapists and speech pathologists who have the training and facilities to carry out the physical program.

(4) The director of the sheltered workshop should be a person with mechanical skill and imagination.

There are certain factors which may cause failure to meet the needs of the disabled in a sheltered workshop program:

(1) Do not spend money on the purchase of an elaborate building or equipment; or accept them as gifts. The success of the program depends upon trained and interested personnel and not on physical equipment.

(2) Do not measure success of the sheltered workshop by the number of disabled persons in the shop or the amount of work produced. Success should be measured by the number of people discharged from your shop to gainful employment in industry or who have been helped in meeting the physical demands of daily living and working.

(3) Do not accept work in the shop which is beyond the capabilities of your workers or which must be completed at a given time.

(4) Do not pamper disabled workers if you expect them to become productive workmen.

(5) Do not go outside of your community for the director of the workshop. Select a man who has worked in a mechanical capacity in a local industry who is interested in your project and disabled people. He will know the community resources for obtaining the type of work suited for the workshop and the possibilities for placing disabled workmen in industry. When you have selected your director, send him around the country to visit other sheltered workshops. The knowledge gained by visiting other workshops will pay large dividends.

Success depends upon outlining purposes, policies and objectives and having the industrial leaders of your community help you work out your plan.

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## DISEASES ARISING FROM OVER-STRAIN AND WEAR AND TEAR OF THE LOCOMOTOR SYSTEM

Henrik Seyffarth, M.D., and Kirsten Moinichen, M.D., Oslo. In RHEUMATISM, 6:2:78, April 1950.

Cervicobrachialgia (c.-br.) has increased very much among office workers during and after the last war and this led to a special study of these diseases. The authors regard the greater part of them as diseases caused by overstrain and wear and tear of the muscles of the skeletal system, whereas they were formerly believed to be of a rheumatic nature. Diseases of unknown or infectious origin or diseases which vary with the temperature and the weather were all called rheumatic. They were also diagnosed as neurosis, because the ordinary neurological investigations showed no organic changes.

The authors show that it is possible by special investigation, of which palpation of the muscles is an important part, to find an organic basis for the symptoms in the muscles, the tendon attachments and the joints (including invertebral disc). Their experiences also show that there is a correlation between the organic changes and the patients' symptoms and between the symptoms and the patients' psychomotor tension. Further, that the symptoms increase during hard work, and that they appear in the parts which are chiefly overstrained.

An investigation in a large insurance company has also shown that the main causes of the increase in cervicobrachialgia were the following: wrong position while working, increased pressure of work, and last, but not least, nervous tension. On the other hand only a few cases of cervicobrachialgia were found to be of a rheumatic nature. The most efficient therapy against these diseases has been found to be: partly treatment of the organic changes with heat, massage and sometimes novocain injections, and partly an aetiological treatment, consisting of rest, re-

(*Continued on page* 50)



## Patient Under Treatment

FOR URINARY TRACT INFECTION

ENJOYS

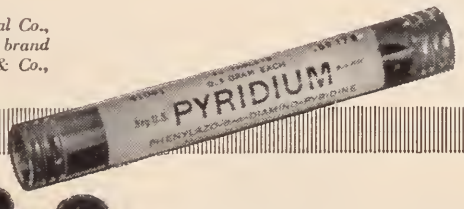
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## Physical Medicine (Continued)

laxation-gymnastics and training in the proper manner of working. The relaxation gymnastics chiefly aim at correct respiration, without which it is impossible to relieve the patient of the psychomotor tension. Without this aetiological treatment the physical therapy treatment is of no use.

In many offices, where the authors have used these forms of therapy combined with prophylactic work along the same lines, it has been possible to eliminate cervicobrachialgi, as a cause of absence, whereas this disease is still very common in other similar offices. Morever, the prophylactic work has led to mental improvement of the employees and their working power has increased.

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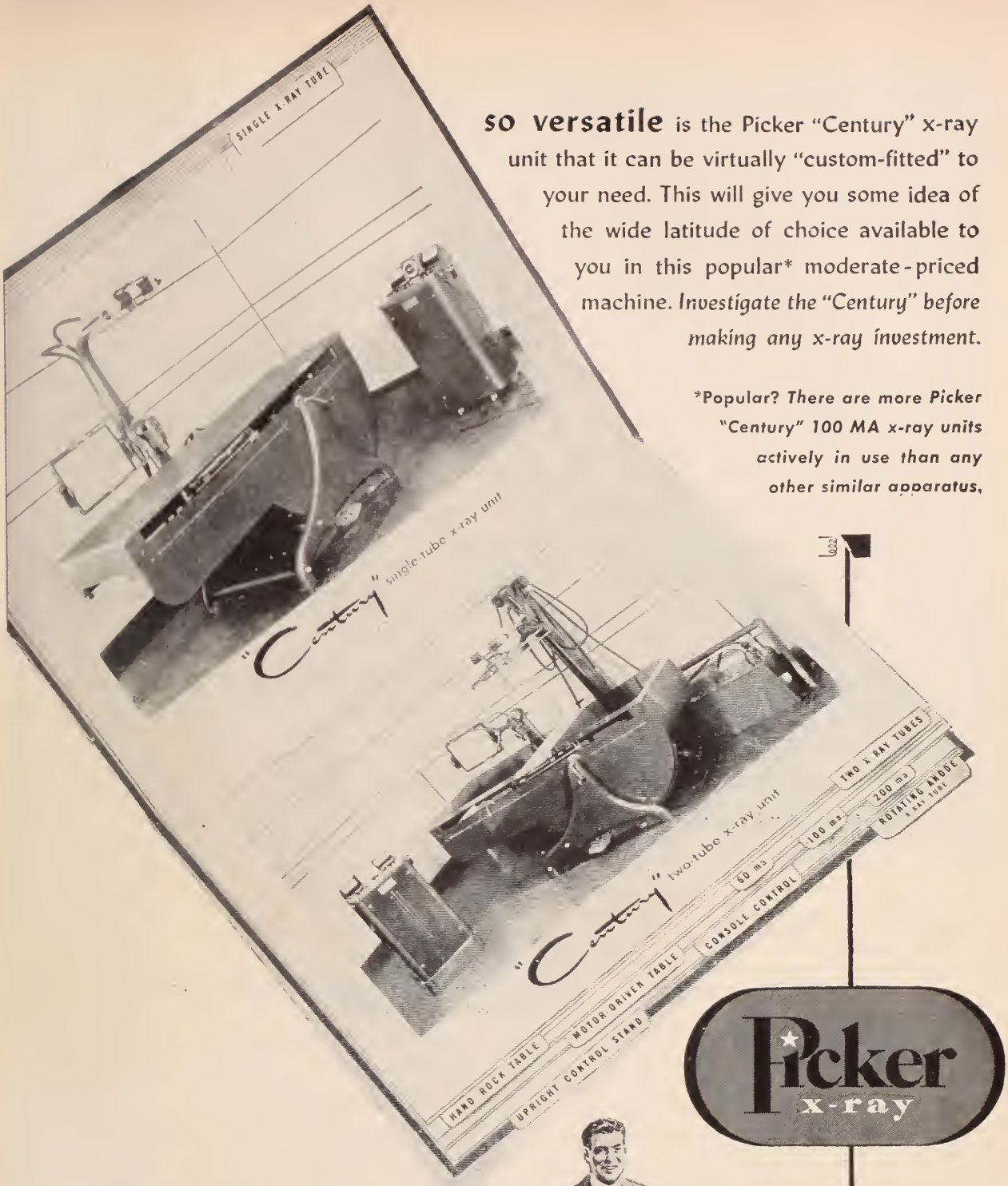
### PHYSICAL ACTIVITY AND PARALYSIS IN POLIOMYELITIS

In THE LANCET, No. 6602, March 11, 1950.

The relation between physical activity and the subsequent development of paralysis in anterior poliomyelitis is of both practical and theoretical importance. There has been an impression for many years that severe paralysis may be precipitated by strenuous activity in the preparalytic stage of the disease, but Ritchie Russell was the first to gather reliable evidence on this point.

In the United States, Horstmann has investigated 411 cases of poliomyelitis in the 1948 epidemic on similar lines. About 20 per cent of these patients had a prodromal stage of mild fever and constitutional symptoms lasting one or two days and then subsiding, to be succeeded three or four days later by a rise of temperature and symptoms of the meningitic phase of the disease. She found no significant difference in the amount of physical exercise taken in this prodromal phase between those who were eventually free from paralysis or only slightly paralyzed and those who developed moderate or severe paralysis. But her findings were quite different when the meningitic stage was considered. Physical activity in the three days before the start of meningitic symptoms did not seem to affect the subsequent paralysis, but any physical exertion in the 48 hours after the onset undoubtedly made the patient more likely to develop moderate or severe paralysis. The incidence of paral-

(Continued on page 52)




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ysis was very much lower in those who rested in bed as soon as symptoms started.

The practical lesson to be learned from Ritchie Russell and Horstmann's studies is that patients must be confined to bed at the beginning of the preparalytic phase. It is generally agreed that during the preparalytic stage the virus is invading the central nervous system, and the susceptibility of the anterior horn cells to the attacks of the virus probably depends on various factors, including nutrition. It has been shown in experimental poliomyelitis is monkeys that exhausting exercise and chilling increase the incidence and severity of paralysis, and conversely that division of a peripheral nerve a few days before infection will protect the anterior horn cells associated with that nerve from damage by the virus. Thus when the poliomyelitis virus has already invaded the nervous system, one factor which increases the chances of damage to anterior horn cells is physiological activity of those cells.

## THE IMPORTANCE AND FUNCTION OF CHILD PSYCHIATRY

Robert P. Odenwald, M.D. In MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA, 19:7:368, July 1950.

The process of growing-up is a complicated phenomenon. Too often development is regarded in terms of physical growth alone. A simple cold, a pain, or an ache arises, and the anxious parents consult the physician. Integral development, however, consists of mental and emotional growth as well as physical, and therefore, the child psychiatrists stand side by side with the pediatrician. A blocking in emotional development is just as important etiologically in behavior disturbances as the blocking of the physical growth.

Let us not forget that many apparently physical disturbances are emotionally conditioned and therefore require more than specific physical therapy such as medication.

In conclusion, our present-day parents, perhaps because of the tense atmosphere of our modern civilization, are not manifesting parental competency in rearing and educating their children properly. The modern home is no longer as it should be, the child's first school. No physician will doubt that maladjusted children are a danger for the coming generation and may increase the number of the mentally ill. Child psychiatry with its own special approach to therapy with children, especially in the form of play therapy, is all-important for the rearing of a future responsible, stable and mature citizenry.

## ELECTROMYOGRAPHY IN DIAGNOSIS OF NERVE ROOT COMPRESSION SYNDROME

Paul A. Shea, M.D., Ward W. Woods, M.D., and Delbert H. Werden, M.D., San Diego, Calif. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 64:1:93, July 1950.

Recent advances in electronics have made possible the clinical use of electromyography in the diagnosis of neurologic lesions.

In compressive lesions of nerve roots the electromyographic method has a high degree of accuracy in determining not only the presence of such a lesion but also its exact location.

Electromyography which utilizes needle electrodes placed intramuscularly in direct contact with the fibers and a cathode ray oscilloscope is more accurate than the method using percutaneous electrodes and an ink-writing recorder.

The use of electromyography in conjunction with clinical examinations and ethyl iodophenylundecylate myelography results in a more accurate and an earlier diagnosis in cases of the spinal nerve root compression syndrome.

## A NEW METHOD FOR ERGOMETRIC MEASUREMENTS

Kurt S. Lion, Eng. D., Edward R. Powsner, B. Sc., Cambridge, Mass. In ARCHIVES OF PHYSICAL MEDICINE, 31:8:508, August 1950.

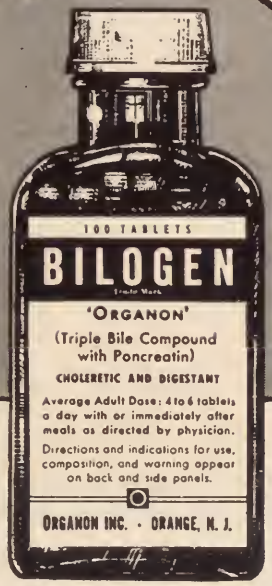
The ergometers commonly used in physical medicine measure either the steady state work done, the continuous power developed or the static force exercised by a muscle or a muscle group. Measurements of this kind are sufficiently indicative for many requirements of the medical practice; they do not, however, permit the direct measurement of transient muscular forces. Such transient forces arise, for instance, when a load is moved from one position to another. Throwing of an object and/or kicking are examples where such transient forces occur, even the short movement of a limb belongs in the category of transient movements.

The principle of an ergometer for transient

(*Continued on page 54*)

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muscular forces is described. The muscles or muscle groups to be tested cause the displacement of a load. The movement is transformed into a voltage which is electrically differentiated two times. The output voltage is proportional to the acceleration of the movement; therefore, it is also proportional to the muscular force causing it. Results of such ergometric tests on the extrinsic ocular muscles are presented.

### DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS OF POLIOMYELITIS: THE MANAGEMENT OF PATIENTS IN THE HOSPITAL ADMITTING ROOM

Wm. P. Frank, M.D., Alhambra, Sam S. Woolington, M.D., Long Beach, and G. E. Rader, M.D., Albuquerque, N. Mex. In CALIFORNIA MEDICINE, 73:1:30, July 1950.

Because of the great variety of early symptoms of poliomyelitis and their similarity to the symptoms of a number of other diseases, in times of epidemic many patients are admitted to hospital on suspicion of poliomyelitis. At such times the prime purpose of the hospital admitting room staff is to distinguish between patients with poliomyelitis (or other diseases requiring immediate treatment) and those who may be referred into other channels.

This presentation (1) points out the superficial similarities of the clinically observable signs and symptoms and of laboratory data in poliomyelitis and in other diseases, and (2) discusses the more occult dissimilarities which aid in differentiation.

### TREATMENT OF PAINFUL AMPUTATION STUMPS

W. Ritchie Russell, M.D., F.R.C.P., F.R.C.P. Ed., and J. M. K. Spalding, B.M., B.Ch. In BRITISH MEDICAL JOURNAL, No. 4670; p. 68, July 8, 1950.

The treatment of painful amputation stumps by repeated percussion to the neuromata has proved successful in most cases.

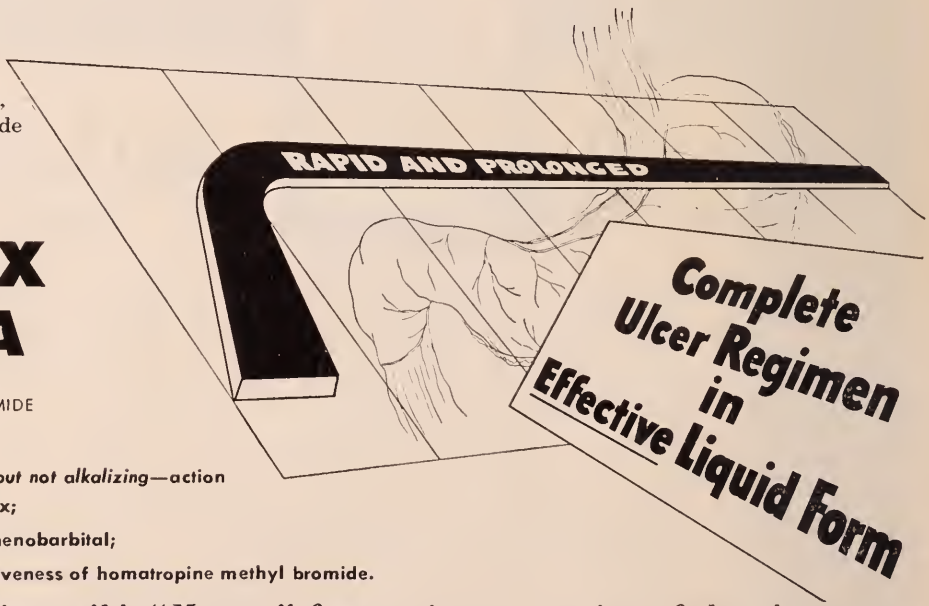
Of 33 cases considered suitable for percussion treatment, 19 reported good or excellent results and 5 were improved. There was only one failure in the first 15 cases treated, but in the last

(*Continued on page* 56)

In palatable liquid dosage, it is now possible to provide complete and effective medical protection for the peptic ulcer patient.

**ALZINOX MAGMA**

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*...in completely dispersible "Magma" form to insure coating of the ulcer crater*

ALZINOX MAGMA WITH PHENOBARBITAL (1/8 gr. per 5 cc.) *and* HOMATROPINE METHYL BROMIDE (1/100 gr. per 5 cc.)—bottles of 8-oz.

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18 cases, some of which were especially difficult, there have been eight apparent failure.

Methods of applying the treatment are described. The neuromata are located as accurately as possible. If they are very tender the arterial supply to the stump is occluded by a sphygmomanometer cuff, as anoxemia renders them less sensitive. Percussion is done with a mallet and an applicator about 15 cm. long. After several minutes the cuff is removed and percussion continued for 20 minutes. An electrical vibrator may be used in place of the mallet, and is of particular value in treating areas beyond the patient's reach. Cases with cold and diffusely tender stumps should be treated by sympathetic block or section rather than percussion.

---

### TENNIS ELBOW

Walter Mercer, M.B., F.R.C.S.Ed., F.R.S.E., Edinburgh. In THE PRACTITIONER, 164:982:293, April 1950.

The condition of tennis elbow, which has also been called epicondylitis and epicondylalgia, is characterized by pain over the outer side of the radiohumeral joint, usually just above the joint line. The name is a misnomer, for tennis as an etiological factor accounts for only a small number of the cases. It occurs in adults as a result not only of sports requiring the use of a racquet, but also of occupations demanding lifting and sudden flexion and contraction of the elbow, such as are required in carrying heavy suitcases, playing the violin, and in the everyday work of blacksmiths and housewives. In some cases the symptoms follow direct trauma to the area.

The name persists, however, and is given to a clinical syndrome of pain and tenderness of variable intensity, accompanied not infrequently by some swelling in or about the epicondyle. The pain usually comes on suddenly during some characteristic racquet game or occupation and rapidly becomes worse. It is relieved by rest but returns when the arm is used again.

The epicondyle does not demonstrate periostitis, although the possibility of an osteitis warrants consideration.

(*Continued on page* 58)



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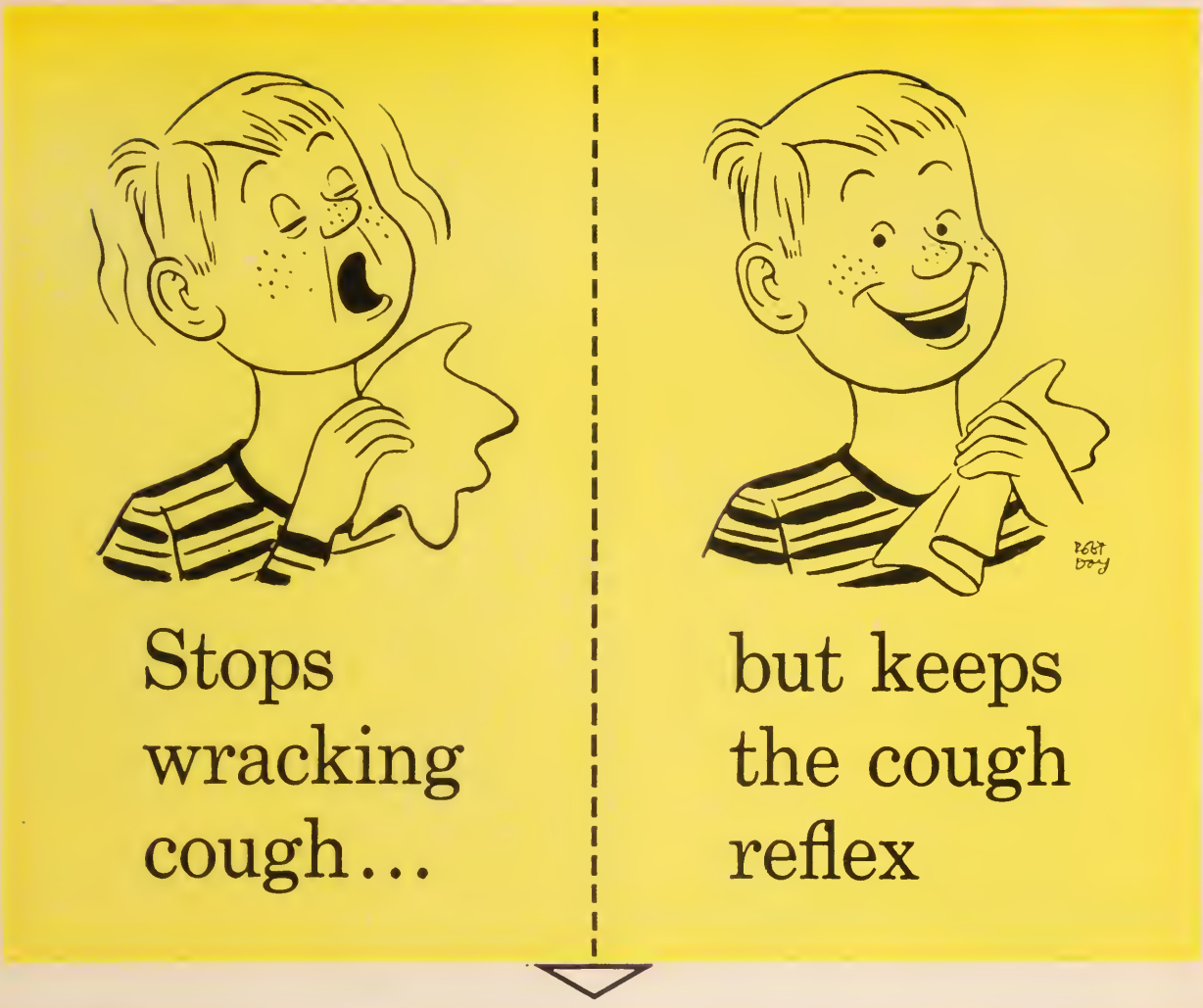
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## Physical Medicine (Continued)

There appears to be little doubt that in certain cases a bursa is present, probably an adventitious one.

Manipulation of the joint in the chronic neglected case is often successful and is frequently accompanied by a crack or a click. Such an occurrence suggests the presence of adhesions in the chronic case. Manipulation is used by Mills (1928, 1937) in the acute case also, and he cites a case in which a patient's elbow "went out"; it was immediately manipulated and he could play tennis in the afternoon.

(1) Treatment of the Extensor Origin Lesion:—Conservative treatment, even if accompanied by radiant heat or short wave diathermy, seldom is completely successful. Injection of procaine followed by full use often aggravates the pain and does not appear to be any more successful. Deep x-ray therapy is used, but with mixed results, as might be expected. If the symptoms are severe, manipulative or operative treatment is indicated.

(2) Treatment of the Intra-articular Lesion:—Very heavy deep massage often is practiced in such cases to irritate the lesion and thus produce a reaction with consequent fibrosis and healing. It is a somewhat painful procedure but in many cases leads to good results, although it is not improbable that recurrence may take place.

The probability is that the typical tennis elbow is the result of an incomplete tear of the extensor origin from the lateral epicondyle, followed by a reactive inflammatory deposit.

Rest in an appropriate position is a reasonable treatment for early cases. In those not responding and in later cases, manipulation will cure an appreciable percentage. For recalcitrant cases, operation is indicated, and of the many procedures suggested the one advocated is an erasion of the extensor origin from the lateral epicondyle.

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### ACCIDENTS IN PHYSICAL MEDICINE

Richard Kovacs, M.D., NewYork. In ARCHIVES OF PHYSICAL MEDICINE, 31:4, 219, April 1950.

Harm may come through unavoidable accidents or through improper practice, and some-

(*Continued on page* 60)



**THROAT SPECIALISTS REPORT**

ON 30-DAY TEST OF CAMEL SMOKERS...

# "Not one single case of throat irritation due to smoking Camels!"

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times it is hard to draw the line between these two factors. The physician is responsible at all times for the safe technic of application of treatment measures by himself and his office aids.

The subject of accidents in physical medicine is presented under three main headings: (1) general causes, (2) forms of injuries, and (3) prevention.

GENERAL PRECAUTIONS

No complaint of a patient during examination or treatment, no matter how trivial, ever should be lightly brushed aside. Proper technic requires that the patient be made comfortable and that he remain so during the entire treatment; that the part under treatment be well supported and relaxed; also, that in a busy office a time clock or other controlling device be used to cut off the current automatically at the expiration of the treatment period.

It is an important rule of the routine of any office that the parts receiving treatment be carefully inspected before and after each application and that any changes be noted.

The final point of safe technic is never to leave a patient out of sight or sound once the treatment has begun. Either the physician or his trained office assistants must be ready at all times to control the current strength, to shut it off altogether if the patient complains or there is any possible sign of danger and to give any needed assistance. There are devices available which are connected to the apparatus and which will shut off the current at the end of the treatment period. The patient should be able, however, to summon help at any time in case of any discomfort. This can be done best by handing the patient a small bell or other audible signaling device.

It is bad psychology ever to discuss any trouble with apparatus before a patient. When receiving electrical treatment for the first time, patients usually are apprehensive, and any doubts expressed about the smooth working of the apparatus may arouse groundless fears, thereby causing them to jump or throw off electrodes at the slightest provocation with possible infliction of a burn. Unremitting vigilance is the price of preventing any mishap from becoming serious.

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# BOOK REVIEWS



PENICILLIN AND STREPTOMYCIN IN THE TREATMENT OF INFECTIONS by Chester S. Keefer, M.S., M.D., Sc.D. (Hon.), Wade Professor of Medicine, Boston University School of Medicine; Director of Evans Memorial and Physician-in-Chief, Massachusetts Memorial Hospital, Boston; Chairman, Committee on Chemotherapeutic and other Agents, National Research Council; Consultant to the Committee on Medical Research, Office of Scientific Research and Development, Washington, D. C. and Donald G. Anderson, M. D., Instructor in Medicine, Boston University School of Medicine; Research Fellow in Medicine at Evans Memorial; Assistant Visiting Physician, Massachusetts Memorial Hospital, Boston, Mass. Edited by Henry A. Christian, A.M., M.D., LL.D., Sc.D. (Hon.), M.A.C.P., Hon. F.R.C.P. (Can.), D.S.M. (A.M.A.), Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; Sometime Clinical Professor of Medicine, Tufts Medical School; Sometimes Physician-in-Chief, Carney Hospital; Sometime Visiting Physician, Beth Israel Hospital; Physician-in-chief, Emeritus, Peter Bent Brigham Hospital, Boston, Mass. 110 Pages $2.50, New York, Oxford University Press, 1950.

This book, reprinted from *OXFORD LOOSE-LEAF MEDICINE*, summarizes the author's wide experience with penicillin and streptomycin. It emphasizes the remarkable influence antibiotics have had on medicine since the first patient was adequately treated with penicillin in the United States in 1942.

As new antibiotics came into use, the underlying principles remain the same, and the more skillfully the physician uses them the greater will become their value. For this reason many will profit by reading this small book.

J. C. S.

MANAGEMENT OF PERIPHERAL ARTERIAL DISEASES: Saul S. Samuels, A.M., M.D. Chief of the Department of Arterial Diseases, Stuyvesant Polyclinic Hospital, New York: Consulting Vascular Surgeon, Long Beach Hospital, Long Beach, New York; Director and Attending Angiologist, Brooklyn Hebrew Home and Hospital for Aged, Brooklyn, New York; Fellow in Surgery, New York Academy of Medicine; Member of Committee on Surgery, New York Diabetes Association; Editor-in-chief, "Angiology"; President Angiology Research Foundation. Publishers: Oxford University Press, New York. 1950. Pages: 345 Price: $7.50.

This small book contains a presentation of the diagnosis and treatment of peripheral arterial disease which is easily read and understandable. In a day where surgery has come to occupy a remarkable and spectacular place, the author, a surgeon, brings to the foreground with emphasis a conservatism in treatment of peripheral artery disease. The book covers obliterative arterial disease, vasospastic disease, vasoconstricting disease, and miscellaneous arterial diseases. The major portion discusses the two most common causes of arterial disease: thromboangiitis obliterans and arteriosclerosis obliterans. Differential diagnosis of these two diseases is thoroughly covered. Great emphasis is placed upon the testing and estimation of the degree of arterial deficiency by objective signs, chemical testing, and oscillometric determinations. Equal emphasis is given to conservative treatment which includes adjustment of the patient's personal life, physical therapy, and direct treatment without resorting to surgery. The author gives the indications for surgery and briefly describes the general principles of technique. Mention is made of the various vasodilator drugs, but in the main they do not come up to the results gained with the use

of physiologic principles. The author may seem repititious and a little wordy, but the re-emphasis does not detract from the quality of the book.

J. W. F.

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Regional Dermatologic Diagnosis. By Ervin Epstein, M.D. with 148 Illust. Lea & Febiger, Philadelphia 1950.

The book fills a real need among those who see considerable dermatology but who are not near the centers where referred cases can easily be cared for in clinics or by the well trained Dermatologist. The book is well written and clear in its descriptions. The illustrations are good with a few exceptions, a picture on page 72 is described as Seborrhoeic Dermatitis and would have been much more typical of Lupus Erythematosus. His charts at the end of each chapter are very valuable for the comparing of symptoms, and associated lesions, etc. The book is printed in a clear readable type with good margins and spacing. Taken as a whole the book is well written, well published and fills a place of need in the medical shelf of books.

H. M. H.

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Tuberculosis: A Global Study in Social Pathology. By John B. McDougall, C.B.E., M.D., F.R.C.P. (Edin), F.R.F.P.S. (Glas.), F.R.S.E. Section of Tuberculosis, World Health Organization. Honorary Medical Advisor to the British Legion Village, Preston Hall, Kent, England. Formerly Medical Superintendent, Crossley Sanitarium, Delamere Forest, Chesire; and Woolley Sanitarium, Hexham, Northumberland; Director, Preston Hall Village Settlement, Maidstone, Kent; Nayland Sanitarium, Colchester and Douglas House, Bournemouth. From 1944 to 1947. Adviser in Tuberculosis to UNRRA in Greece.) Baltimore. The Williams and Wilkins Company, 1949. 455 pages. $6.00.

This is an epidemiological study of tuberculosis with emphasis on public health aspects of the problem. The first part of the book gives mortality and morbidity rates of tuberculosis in different countries, the second gives general considerations affecting mortality and morbidity, and the remainder of the book is devoted to investigation of the problem in a community.

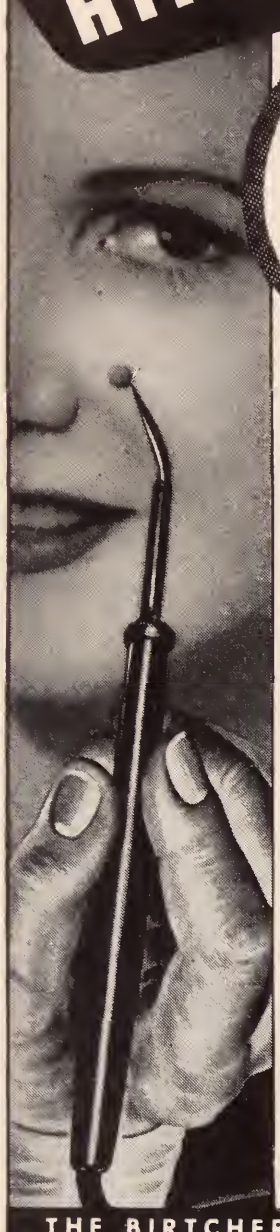
The assembled material is well organized and clearly presented. In the few places where the author presents his own opinions they are authoritative. This is a useful book for epidemiologists and phthisiologists.

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A Histology of the Body Tissues with a consideration of their functions, by Margaret Gillison, Diploma of Bedford Physical Training College, Diploma in Physical Education of the University of London, Member of the Chartered Society of Physio Therapy, Lecturer in Physiology at the I.M. Marsh College of Physical Education, Liverpool. Foreword by R.C. Garry, D.Sc., M.B., Ch.B., F.R.S.E., Regius Profes-


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sor of Physiology, University of Glasgow—220 pages, 103 illustrations, $3.50. Williams and Wilkins Co, Baltimore, 1950.

This book integrates histology and physiology as might be suitable for students of physiotherapy and physical education. The drawings, made by the author, are excellent.

J. C. S.

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Psychiatric Sections in General Hospitals by Paul Haun, M. D., Med. Sc. D., Asst. Prof. Phychiatry, Georgetown University Medical School. 80 pages, 15 plans, 1st Edition February 1950, $4.00. Architectural Record Book, F. W. Dodge Corporation, Garden City, New York.

This little book is one of Architectural Forum's series on hospital designing. Required reading for physicians, architects and laymen concerned in building or remodelling a general hospital.

J. C. S.

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Clinical Pathology: Application and Interpretation. By Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock, Arkansas. 397 pages with 32 figures. Philadelphia and London: W B. Saunders Company, 1950. Price $6.00.

One would not think of practicing medicine without making some use of the laboratory. Obviously the physician does not have to know how to do the laboratory test, but he must know when to do it, how to interpret it, and what its limitations are.

This book is designed for application and interpretation of clinical laboratory tests. Technic of the various tests is left to bulkier works. The material is arranged as the clinician uses it. There is an interesting chapter on clinical laboratory studies in surgery, followed by a similar chapter on obstetrics. The appendix includes laboratory aids in symptom diagnosis and gives normal values of various routine examinations.

The book is not intended to be a laboratory manual or a text book of medicine, but it should be of value to anyone concerned with application or interpretation of laboratory procedures. The book is well arranged and readable, and the author's main point is well presented and worth quoting "Insufficient or improper use of the laboratory is most often an evidence of ignorance; excessive reliance on laboratory results is proof of inexperience." As Christian and others have pointed out many times, the tendency has been to develop a generation of physicians who place more reliance on the laboratory than on their own clinical acumen, perhaps as a reaction from the previous generation who were forced to depend on their own sense for diagnosis. The temptation to put undue faith in laboratory results is compelling; anything down in black and white is impressive to patient and physician. One must remember to deal with the patient as a whole, not as a vaguely connected series of chemical reactions; and a book of this kind is a step in that direction.

J. C. S.

Peptic Ulcer: by A. C. Ivy, Ph.D., M.D., D.Sc., LL.D., Vice President of the University of Illinois in Charge of Chicago Professional Colleges; M. I. Grossman, Ph.D., M.D., Associate Professor of Physiology, University of Illinois, College of Medicine; and William H. Bachrach, Ph.D., M.D., Research Associate in Physiology, University of Southern California, School of Medicine.

This is a remarkable book. Almost everybody has written something about peptic ulcer, but it remained to Ivy and his associates to write almost everything about it. The book consists of a systematic review of all ulcer literature for the past hundred years and this enormous mass of material has been accurately tabulated and interpreted. It is divided into four parts, Introduction, Pathogenesis, Diagnosis and Treatment. These are further divided into chapters, and under each heading the examination and discussion of the subject is exhaustive; for instance there are fully eighteen pages on the definition of the general term "ulcer", which must be a record.

The importance of the book does not lie in the mere collection of the century's available ulcer literature in one volume, but in the critical analysis of this literature by Ivy and his associates. They have diligently applied their great experience to the interpretation of much conflicting information, in too many cases improperly controlled or standardized. Their own numerous contributions are catalogued and evaluated as objectively as others.

Each chapter is preceded by an outline, contains a section on comment and is followed by a summary. The last chapter of each section is a summary. One of the most valuable features of the book is the recurring suggestion for further investigation. In many cases the authors recommend specific observations that would aid in the clarification of a certain problem.

This book admirably fulfills its mission. The field of peptic ulcer is completely covered, experimental and clinical data from hundreds of authors are presented under one cover in readily accessible form, and suggestions for further investigations are abundant. It is not intended for beginners. The manner necessary for its presentation does not lend itself to easy reading. This is to be expected in a book that summarizes a century of work on a subject like peptic ulcer, where much has been written but little is known. This book is a milestone in ulcer literature.

J. C. S.

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In 1937, Wade H. Frost concluded that the point had been reached in the United States where there is a gradual downward trend in the incidence of tuberculosis, and that, barring major upsets in civilization, the eventual eradication of the disease can be expected. The continued decline in the annual number of deaths from tuberculosis during the past 12 years, in spite of the adverse conditions caused by a great war, is ground for confidence in the accuracy of Frost's conclusion. A. C. Christie, M.D., Pub. Health Reports, June 2, 1950.



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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

ORTHOPAEDIC SURGERY: By Walter Mercer, M.B., Ch.B., F.R.C.S. (Edin.), F.R.S., Fourth Edition. The Williams & Wilkins Company, Baltimore, 1950. 1016 pages. $10.00.

YOUR DEAF CHILD (A guide for Parents): By Helmer R. Myklebust, Professor of Audiology, Northwestern University. Foreword by Hallowell Davis, M.D., Charles C. Thomas, Publisher, Springfield, Illinois. 133 pages. $2.50.

BRONCHOESOPHAGOLOGY: By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S. and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S. 366 pages with 260 figures. Philadelphia and London: W. B. Saunders Company, 1950. $12.50.

REGIONAL ORTHOPEDIC SURGERY: By Paul C. Colonna, M.D., Professor of Orthopedic Surgery, University of Pennsylvania Medical School. 706 pages with 474 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $11.50.

EVALUATION IN PHYSICAL EDUCATION (Better Teaching Through Testing) By M. Gladys Scott, Professor of Physical Education, State University of Iowa, and Esther French, Professor and Head, Department of Health and Physical Education for Women, Illinois State Normal University. Illustrated. The C. V. Mosby Company, St. Louis, 1950. 348 pages. $4.00.

PRINCIPLES OF GENERAL PSYCHOPATHOLOGY (An Interpretation of the Theoretical Foundations of Psychopathological Concepts: By Siegfried Fischer, M.D., Clinical Instructor in Psychiatry, University of California. Philosophical Library, New York, 327 pages. $4.75.

PROGRESS VOLUME (to accompany Hyman's Integrated Practice of Medicine) An appraisal of latest developments in therapeutics prepared by Harold Thomas Hyman, M.D., to accompany his 4-volume Integrated Practice of Medicine. Contains cross reference to the original 4 volumes and an index system to all 5 volumes. 734 pages. Philadelphia and London. W. B. Saunders Company, 1950. Price $10.00.

PROGRESS IN GYNECOLOGY: Volume II. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School and Somers H. Sturgis, M.D., Clinical Associate in Gynecology, Harvard Medical School: Frune & Stratton, New York, 1950. $9.50.

THE PHYSICIAN EXAMINES THE BIBLE. By C. Raimer Smith, B.S., M.D., D.N.B., Philosophical Library, New York. 394 pages. $4.25.

NEUROSIS AND PSYCHOSIS. By Beulah Chamberlain Bosselman, M.D., Associate Professor of Psychiatry,


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## CHANGE OF ADDRESS

**Send changes of address with old address label to Illinois Medical Journal, 30 N. Michigan Ave., Chicago 2, Ill. Changes received after the first of the month will not be made until the following month.**

University of Illinois College of Medicine, Chicago, Illinois. Foreword by Francis J. Gerty, M.D., Professor of Psychiatry and Head of the Department, University of Illinois College of Medicine, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. 172 pages. $4.50.

ANTIHISTAMINES, Industry and Product Survey. By Nathan Wishnefsky, B.S., in Phar., B.Ch.E., M.Ch.E., R. S. Aries & Associates. Chemonomics, Inc. Publishers, 400 Madison Avenue, New York 17, N. Y., Copyright 1950 by R. S. Aries & Associates. Price $5.00.

FREUD, Dictionary of Psychoanalysis. Nandor Fodor and Frank Gaynor. Philosophical Library, New York. $3.75.

SUPPLEMENTS TO OXFORD LOOSE-LEAF MEDICINE. Oxford University Press, Inc., 114 Fifth Avenue, New York 11, N. Y.

EMERGENCIES IN MEDICAL PRACTICE: Edited by C. Allan Birch, M.D., F.R.C.P., Physician, Chase Farm Hospital, Enfield. 131 illustrations, 8 in full colour. Second Edition. The Williams and Wilkins Company, Baltimore, 1950. 564 pages. $5.50.

RESEARCHES IN BINOCULAR VISION: By Kenneth N. Ogle, Ph.D., Section on Biophysics and Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic, Rochester, Minnesota. 345 pages with 182 figures and 26 tables. Philadelphia and London: W. B. Saunders Company, 1950. $7.50.


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## ARMY MEDICS TEST NEW BURN DRESSING IN KOREA

Two new oversized dressings for burns or wounds will soon join other medical advances which help to provide the best medical treatment obtainable to G. I.'s fighting in Korea, according to Major General R. W. Bliss, Army Surgeon General.

One of the projects of the Army Medical Service's Research and Development Board, the new dressings consist of an inside or wound layer of highly absorbent fine mesh gauze, which may be treated to reduce irritation to wounds; and an outside, nonabsorbent layer that prevents bacteria from entering the wound or burn. These qualities will permit the dressings to be worn for as long as 14 days, whereas present type burn dessings must be changed every day or two, depending upon the degree of the burn.

Smallest of the dressings, 19 by 34 inches, are about five times larger than the largest size now in use. The larger one, for more extensive burns or wounds, is 34 by 45 inches. These dressings were developed for use during the first aid phase of treatment to give the casualty every benefit of Army medical research possible, and to improve his chances of reaching a hospital for definitive treatment.

These dressings will offer greater protection to a large burned area, such as a tanker might sustain when his tank is hit, or a soldier might receive from the burst of a high explosive bomb. In the case of severely burned extremities, a dressing can be wrapped around the affected part.

Wounds resulting from blast, where small particules of loose debris have entered the skin over a considerable area, may also be treated with the dressings. In the event of an atomic bomb burst, both dressings would be invaluable.

The smaller dressing also may be used as an arm splint when tightly applied. The dressings are packed in a plastic bag that is resistant to water, moisture, and heat.

## NEW ZEALAND'S "FREE MEDICINE" SCHEME EXPERIENCING DIFFICULTIES

After 12 years of operation, New Zealand's widely hailed "social security" medical plan is collapsing under its own weight, a regular correspondent of the Journal of the American Medical Association reports.

Writing from Brisbane, Australia, for the (November 4) issue of the Journal, he cited the annual report of Dr. Duncan Cook, director of clinical services, to the New Zealand Parliament. In that report, Dr. Cook said:

"Increase in the cost of general medical services and pharmaceutical supplies have been of such magnitude as to lead to serious misgivings as to whether state medical insurance against sickness is practicable or




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whether the best method of payment for services has been adopted."

Proponents of socialized medicine in this country have been pointing to the New Zealand program as an example of what government medicine can do

The Journal correspondent said that in 1938 after a period of economic depression, the people of New Zealand welcomed the scheme, "with its free medicine, free hospitalization and nominal payments for medical attendance."

He added: "But the original humanitarian concept has become a political football. Year by year benefits have been increased as a bait for the electors, until today the cost of social security is the biggest item in the national budget. In its last term of office last year, the labor government appeared to the New Zealand branch of the British Medical Association to stop the abuses and arrest the drift. One of the problems concerns 'shopping.' If the doctor does not satisfy the patient in what he feels are his prescription needs, he will go to a more obliging doctor. The government is now considering a nominal fee for each prescription, but the major problem remains to be solved."

Dr. Cook in his report to Parliament said that "unless the desired reforms made possible by the new legislation last session provide satisfactory remedies, the present system of social security medicine in New Zealand will have to be either modified considerably or replaced by a system more readily controllable."

## REPORT POSSIBLE HARDENING OF ARTERIES FROM CORTISONE, ACTH

The possibility that hardening of the arteries will result when cortisone and ACTH are administered to patients over a prolonged period of time is brought forth by three doctors associated with Mount Sinai Hospital, N. Y., who are studying the side-effects of the newly discovered drugs.

"The factor of prolonged therapy assumes a particular importance," said Drs. David Adlersberg, Louis Schaefer and Stanley R. Drachman, "because of the increased availability of these drugs. It may be expected that many patients with chronic diseases will now receive long courses of cortisone and ACTH therapy."

Writing in the (November 11th) issue of the Journal of the American Medical Associaiton the doctors report that in 36 per cent (17 instances) of the 47 courses of the drugs administered, cholesterol was elevated to excessive levels. This condition is called hypercholesteremia.

This is of extreme importance because medical researchers believe that a definite relationship exists between hypercholesteremia and hardening of the arteries.

The doctors further observed that the longer the treatment and the larger the dosage the more pronounced the condition became.

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## ACUTE INTUSSUSCEPTION

Acute intussusception is one of the most common diseases of infants and children requiring an emergency abdominal operation. The diagnosis must be made early and surgical treatment instituted at once. Delay in operation or error in diagnosis, thus retarding proper treatment results in an increase in the mortality rate of this serious disease.

. . . The majority of the investigators agree that the etiology of acute intussusception is practically unknown. In scrutinizing these nine cases, there is no cause given as to why the condition occurred. Ladd and Gross made a study of this subject and found that there was no cause in 95% of this series. Oberhelman and Condon report recently that no cause was found in 83.1% in a study of ninety-five cases. Rodney Maingot considers irregular peristalsis due to an acute enteritis, swollen Peyer's patches, allergic state or faulty diet, all possible factors. Meckel's diverticulum and intestinal tumors are sometimes found as causes.

. . . The symptoms of acute intussusception are clear and definite, as noted from Table I. All of the nine cases had vomiting and pains, seven of the nine cases had bloody stools; six had a palpable mass and six had symptoms of intestinal obstruction. None were in shock.

The diagnosis of acute intussusception should not be difficult. The mother will often give the first clue by stating that her child is sick and is passing blood in the stools. One it then alerted to rule out acute intussusception. A careful history will reveal that the child has vomited and cried with some abdominal pains.

Physical examination will show a very tender abdomen upon palpation and in the majority of cases, a palpable, "sausage" mass will be found along the course of the large intestine. Bailey advocates that the abdomen be examined without awakening the child, if asleep and over the sheet; if awakened, to be sure that the hand is warm. *Excerpt: Acute Intussusception: Report of Nine Cases, Ovid F. Pomerleau, M.D., Sisters Hospital, Waterville, Me., The J. of the Maine Med. Assoc., Sept.,* 1950.


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## PROLONGED LABOR

The report incidence of prolonged labor in the literature is quite constant, ranging between 2.7 and 4 per cent. In searching for etiologic factors, we return again and again to the problem of abnormal uterine muscle physiology. Positions, presentation, type of pelvis or prenatal complications apparently do not contribute in any degree to causing prolonged labor. The only consistent clinical observation is the preponderance of young primigravida.

The prolongation of the labors invariably is in the first stage and is the result of faulty and ineffectual contractions. A lack of coordination between muscular and nervous elements would well fit this condition.

Cosgrove and more recently Donnelly have confirmed our impression that many of the operative procedures, such as Voorhees bags, stripping of membranes and Duhrssens incisions are of limited value and are definitely dangerous. We have had no instance in which Duhrssens incisions were required. Williams in 1943 showed the danger of cesarean section in cases of prolonged labor in his analysis of 206 deaths in prolonged labor. We feel that our efforts to protect the parturient patient (sedation, hydration, antisepsis, nutrition and elimination) throughout the labor have borne fruit. *Excerpt: Prolonged Labor, Herbert E. Schmitz, M.D., Charles J. Smith, M.D., and N. J. O'Dea, M.D., all of Chicago; J. Missouri M. A., Oct.,* 1950.

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Even after clinical follow-up in minimal tuberculosis has confirmed the interpretation of the ill-defined X-ray shadow, the physician is faced with another and perhaps more serious problem. He must then cope with the question of the lesion's significance, and must decide upon the course of action to be taken in its management. Will the patient need to undergo hospitalization and surgical procedure? Can the lesion be managed under a home-care regimen? Or will it be sufficient to place the patient under long term observation, imposing only token limitations upon normal activity? It will be most urgent that these questions be resolved properly and decisively.

These are but a few of the problems which our screening survey experiences in communities and hospitals pose for us and for the medical profession generally. Meeting them directly and fully is the best assurance of effective tuberculosis control. Robert J. Anderson, M.D., Journal-Lancet, April 1950.

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*Minish, L.T., Jr.: Headache, Kentucky M.J. 48:66 (Feb.) 1950

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## INTESTINAL AMEBIASIS

The accumulated evidence indicates that typically the onset of intestinal amebiasis is so insidious that the patient remains in a state of marginal ill health for protracted periods of time, and the appearance of such evidence of irritation to the colon as an increased daily number of semi-formed stools, flatulence, mild colonic spasms, or constipation come to be accepted as normal. It seems probable that patent amebic ulcers remain small and few in number in the absence of exposure to massive reinfection or decreased capacity for tissue repair. Consequently, the development of extensive cicatrization, adhesions, amebomas, and metastatic extension to the liver or other extraintestinal organs occur in the absence of conspicuous signs of intestinal infections. Musgrave found typical amebic ulceration of the colon in 50 Filipinos who had died of diseases other than amebic infection and who had not given any history of amebic diarrhea or dysentery. Faust attemped to answer the question, "Are there perfectly healthy carriers?," by examining the intestines of 202 individuals who had died as the result of accidents and found that 13 (6.4 per cent) harbored E. histolytica in their large intestines. Of these 13 cases, seven showed typical amebic lesions which were superficial; in six no microscopic lesions were found, although, in four of the six, amebas were demonstrated throughout the entire length of the large intestine; in the remaining two cases the infection was diagnosed by finding a single cyst in each instance.

. . . .A definite diagnosis is entirely dependent upon microscopic demonstration and identification of trophozoites or cysts of E. histolytica. A prevailing idea that the laboratory diagnosis requires the exercise of exceptional personnel is fallacious. It is true that occasional individual amebas or cysts are difficult to identify but any intelligent laboratory technician who is sufficiently skilled to perform a differential leukocyte count can be taught the essential differential criteria within a few hours. *Except: "The Incidence of Amebiasis in the Albany (New York) Area", Robert C. Towse, M. D., Albany, N. Y.; D. A. Berberian, M.D., Albany, N. Y.; and E. W. Dennis, Ph. D., Rensselaer, N. Y. (From the Med. Dept. of Winthrop-Stearns Inc., and the Sterling-Winthrop Research Institute), N. Y. State J. of M., Sept.* 1, 1950.



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